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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. The editors welcome manuscripts that are the original work of the author(s) 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, topical clinical articles, literature reviews, case studies, and quantitative research. Submissions are encouraged that relate relevant theory to clinical practice or provide original research relating to program or treatment outcomes and processes.

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PREFACE
Clinical Innovations

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Clinical Innovations are the cutting edge of the field, carving a daring pathway forward and charting a course for the future of therapy and treatment. In the previous issue of *Journal of Therapeutic Schools and Programs (JTSP)*, Ellen Behrens, Chief Editor, announced the new format of Special Issues for the JTSP and wrote "the JTSP Editorial Board expects that this new journal format will inspire salient research on topics of interest to programs and providers." Each year the journal will feature one special issue or topic that is of interest to NATSAP member programs. The present issue is devoted to clinical interventions.

I take this as a charge and call to action in accomplishing the mission of the JTSP and the mission of NATSAP as carried forward to this point. In doing so I hope to honor the work of those who have inspired me: Dr. Michael Gass who years ago invited me to write an article for the journal, and Dr. Ellen Behrens who has invited me to guest edit this special edition. These pioneers in our field have inspired me. I believe that we can all be inspired by highlighting the brilliant clinical innovations that have equipped so many NATSAP programs with the tools to forward the therapeutic growth and progress of thousands of youth. I believe that we can advance the evidence base of the most effective interventions by researching innovations, such as those included in this issue of JTSP, and publishing the results to the mental health field as a whole.

It takes a united vision and the right *way of being* (Arbinger, 2006) to work collaboratively as an organization to foster world class standards of treatment. To do so, our primary interest must be the benefit we can bring to so many lives through sharing what we have learned and working together. This has long been a core tenet of NATSAP's mission and I want to echo Dr. Behrens' gratitude and acknowledgments to Dr. Jared Balmer, the board liaison for research, Dr. John Santa, the chair of the research committee, outgoing NATSAP Executive Director Cliff Brownstein, and all those associated with the JTSP for the leadership and constant support of this vision. As we continue this effort together, we will undoubtedly impact the direction of mental health for adolescents and young adults.

With this vision to guide me, I have encouraged the authors in this special issue of the JTSP to illustrate the development of clinical innovations and how these have been uniquely applied. Therefore many of these innovations are described in context of the treatment programming in which they are practiced. Innovations highlighted in this issue range from wilderness to transition care and include interventions to support children, adolescents, and adults as well as line staff and therapists. There is even an article dedicated to de-mystifying the research process to invite practitioners to validate their innovations. To create the flexibility to present cutting edge innovations, some authors have been given special dispensation to speak from a first-person voice in hopes that their trail blazing efforts will inspire research to duplicate and validate these interventions. Though most of the papers in the present issue are perhaps best described as program-level case studies, which are not based on quantitative research, this journal remains committed to serving as a primary outlet for empirical research for residential, outdoor, and transition programs. Therefore, I am calling for programs to investigate the innovations described in this special issue and begin researching the use of these practices in a variety of settings and samples. In this way, we can all follow what is known as the *scientist practitioner model* (Baker & Benjamin, 2000) in which practice (clinical innovations) informs theory (as presented in this special issue) and that theory in turn informs research. Within the scientist practitioner model, whether professors or clinicians, we can all work together to inspire the future of therapeutic treatment. I hope the present issue propels our research forward by suggesting innovations worthy of empirical investigation.

References

The anatomy of peace: Resolving the heart of conflict. (2006). San Francisco, CA: Berrett-Koehler.

Baker, D. B., Benjamin Jr., L. T. (2000). The affirmation of the scientist-practitioner: A look back at Boulder. *American Psychologist, 55(*2), 241–247.

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Mindfulness-Based Practice in Outdoor Behavioral Healthcare

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Second Nature

Abstract

Interest in the application of mindfulness-based practice (MBP) in adolescent mental health is a rapidly growing field of inquiry. While empirically validated studies with adult populations demonstrate the efficacy of structured MBP in moderating symptoms of anxiety, social anxiety, depression, stress and other conditions, research with adolescent and young adult populations is relatively new. As the prevalence of mood disorders continues to accelerate among the adolescent population, treatment modalities which specifically address emotional self-regulation and self-acceptance are increasingly important. Outdoor behavioral healthcare (OBH) seeks to provide innovative treatment to adolescents with these complex issues and could benefit from incorporating mindfulness-based practice into the treatment process. This study reviews current literature about the utilization of core mindfulness practices to support emotion regulation with adolescents in traditional therapy settings and OBH, and includes the findings from a survey assessing the prevalence and efficacy of MBP in outdoor behavioral healthcare (OBH), as well as limitations and suggestions for further research.

Keywords: outdoor behavioral healthcare, mindfulness-based practice, mindfulness, emotion regulation, adolescent mental health

According to researchers at the National Institute of Mental Health, the lifetime prevalence of a mental health disorder for 13-18 year olds is 46.3%, and just over 20% of these adolescents suffer from a severe mental disorder (Merikangas, et al 2010). Most common disorders for which this age group has sought mental health treatment are mood disorders (43.8%) and anxiety disorders (32.2%) (Merikangas, et al, et al). Despite the research showing the superior effects of cognitive behavioral therapy and interpersonal therapy for depression in adolescents, after five months the effectiveness of therapy was no longer significant (Watanabe, Hunot, Omori, Churchill, & Furukawa, 2007). Likewise, a recent study by Davis, May, and Whiting (2011) found that many treatments for anxiety in children and adolescents have not yet been demonstrated as effective. Innovative and effective treatments are needed to address the particular challenges of emotional dysregulation present in mood and anxiety disorders in adolescents.

Emotional awareness and expressivity are skills associated with and an important precursor to emotion regulation (Saarni, 1999, as cited in Chambers, Gullone & Allen, 2009). Facility in emotional and social skills is a critical aspect of self-management. It encompasses understanding how to work cooperatively with others, channel motivation, sustain attention, deal with frustration, respond appropriately to challenges, and avoid risky behaviors. Poor emotional awareness and expressivity have been linked to problematic behavior and peer relations in childhood, and poor understanding of emotions is associated with internalizing problems in adolescence (Penza-Clyve & Zeman, 2002). As recent research suggests (Chambers, Gullone & Allen, 2009) treatment strategies and interventions which increase emotional literacy, emotional identification skills, and healthy emotional expression in adolescents provide a moderating effect on problem behaviors and substance abuse.

Emotion Regulation in Adolescents

Cooper, Wood, Orcutt & Albino (2003) suggest that dysfunctional styles of regulating emotions and moderating emotion-driven behaviors may be an important indicator of future risky behavior by

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adolescents. Adolescents who lack skills for managing their emotional experiences may be more likely to engage in risky or maladaptive behaviors to avoid, suppress or override challenging emotions. The stress vulnerability model (Cooper, Russell, Skinner, Frone, & Mudar, 1992) proposes that individuals who struggle to identify and work through their emotions may turn to using substances to alleviate distressing emotional states. These skill deficits may involve difficulties in a variety of emotion-related competencies, including; regulating emotions, being aware of one's emotions, and effective expressing of emotions. Lower self-regulation in early adolescence was associated with a greater number of sexual partners in late adolescence (Raffaelli & Crockett, 2003) and a lack of control in childhood and early adolescence predicted later adolescent internalized and externalized behaviors (Caspi, Henry, McGee, Moffitt, & Silva, 1995). Conversely, greater emotional restraint and regulation was associated with lower drug use across an 18-month period in early adolescence (Farrell & Danish, 1993).

From a developmental standpoint, adolescents are expected to be less able than adults to use words to describe their feelings, a task referred to as emotional awareness (Coffey & Hartman, 2008). Adolescents low in emotional awareness many not know what they are precisely feeling, but do know that they are experiencing emotional distress (Penza-Clyve & Zeman, 2002). Adolescents with low emotional awareness may be able to identify their affective states in simple terms (mad, sad, glad, happy, angry), but are not able to perform more sophisticated tasks or intentionally regulate their responses. Ciarrochi, Heaven, & Supavadeeprasit (2008) suggest that emotional awareness can be measured in adolescents and acts as an antecedent to increasing emotional and social well-being.

Emotional Dysregulation and Maladaptive Behaviors

Emotion regulation involves strategies to respond to the demands of a present circumstance in a manner that is socially tolerable and sufficiently flexible (Eisenberg, Spinrad, & Eggum, 2010). The ability to positively regulate emotion is viewed by Eisenberg et al. and other contemporary researchers as a foundation for well-being and positive adjustment throughout the life span (2010). Emotion regulation processes include management of distress and modulation of excitement, identification and acceptance of emotional experiences, prioritizing among competing goals, sustaining motivation, and adaptive adjustment of behavioral responses (Arnsten & Shansky, 2004). A core feature of many adolescent-onset emotional and behavioral problems, difficulties in emotion regulation, are associated with anxiety, depression, self-harm, conduct problems, eating disorders, and substance abuse. Adolescents with low distress tolerance are significantly more likely to engage in harmful risk-taking behavior (Cisler, Olatunji, Felder, & Forsyth, 2010), compared with peers who display more developed coping strategies and healthy developmental growth.

For adolescents, maladaptive behaviors often provide transient relief (positive reinforcement) or serve to permit escape from emotional pain (negative reinforcement) (Andersen & Teicher, 2008). Alternatively, teens may seek to moderate their distress through behavior which reinforces the association between automatic thought and negative affect--through rumination or obsessive worry, they may unsuccessfully seek to resolve problems and regulate feelings through reexamination or re-experiencing of a distressing situation. This practice of rumination heightens attention to distress cues and amplifies rather than attenuates distress, while reducing their capacity to engage in healthy emotion regulation (Boyce, 2005).

Eisenberg, Spinrad & Eggnum (2010) describe emotion dysregulation as 'the hallmark of psychopathology.' An individual who struggles to respond and interact with their environment and/or stressors in a resilient and adaptive manner, or who experiences symptoms of anxiety, depression, poorly controlled behavior and isolation, may indicate an individual who is at risk of developing more complex mental health disorders. Dysregulation of emotion is identified as a primary indicator in over half of the DSM-IV Axis I disorders, and all of the Axis II disorders (Cisler, Olatunji, Fedler & Forsyth, 2010).

As emotion regulation has been identified as a primary indicator of emotional health and/or of a disorder of emotional competency, the mechanism by which adolescents are able to access and understand their internal emotional landscape appears to be an essential component of self-regulation. As self-awareness has been identified as the primary ingredient in identifying and understanding our motivations, impulses and actions, there exists a need for a means of self-exploration, which provides a non-judgmental and honest appraisal of our emotional states and our reactive nature in response to

stress or threat. This foundation of emotional awareness has been described as mindful awareness, or simply, mindfulness.

Mindfulness

Mindfulness is defined as paying attention in a certain way: on purpose, in the present moment, and non-judgmentally (Kabat-Zinn, 1994). Mindfulness consists of a number of dimensions, including non-reactivity to present experience, observing experiences, acting with awareness, describing/labeling with words, and non-judging of experience (Baer, 2003).

Several interrelated theories have been offered for why mindfulness is associated with a greater sense of well-being. In the mindful state, thoughts may be more likely to be experienced for what they are (transitory events which come and go), rather than solid and unchanging facts. For example, the thought "I am a failure," can be observed as a passing event, rather than a statement about reality. When negative thoughts are viewed as valid reflections of what is real, the thought "I am a failure" leads to a decline in self-esteem, loss of motivation, and reflexive and impulsive reactions to the environment and interactions with others (Caspi, Henry, McGee, Moffitt & Silva, 1995).

While there are a variety of disciplines and practices that can cultivate mindfulness (e.g. yoga, tai chi, martial arts, qigong); (Siegel, 2007), most empirical research and theory has focused on the development of mindfulness through mindfulness meditation. With this approach in mind, mindfulness meditation refers to:

> A family of self-regulation practices that focus on training attention and awareness in order to bring mental processes under greater voluntary control and thereby foster general mental well-being and development and/or specific capacities such as calm, clarity, and concentration (Walsh & Shapiro, 2006, p. 228).

While Tibetan and Zen Buddhist meditation styles also cultivate mindfulness, the term *mindfulness meditation* is typically used to describe a form of meditation known as Vipassana, which is derived from Theravada Buddhism (Gunaratana, 2002). Vipassana, the Pali word for "insight" or "clear awareness," is a practice designed to develop awareness (Gunaratana, 2002). By intentionally applying one's attention to one's environment, emotions, bodily sensations, and thoughts, mindfulness is systematically cultivated through Vipassana (Bodhi, 2000).

Although it is reasonable to assume that any type of mediation will cultivate some aspect of awareness and be beneficial to the individual, research suggests different brain activities are activated by different styles of medication practice (Valentine & Sweet, 1999). For example, concentrative forms of meditation (e.g. focusing on a mantra) have shown to be less effective in stimulating the part of the brain associated with metacognition (Siegel, 2007) than mindfulness meditation. As brain images technology advances, researchers are able to explore how differing mindfulness practices such as loving-kindness (tonglen) meditation, single-point meditation, and moment-to-moment non-judgmental meditation correlate to physiological outcomes and brain function (Lutz, Slagter, Dunne & Davidson, 2008).

In an attempt to operationalize mindfulness as a measurable psychological construct, Bishop, et 3800 W Starr Pass Blvd, Tucson, AZ 85745 al., (2004) proposed that mindfulness incorporates two dimensions: self-regulation of attention, and a particular orientation to experience. Self-regulation of attention involves observing, without commentary or judgement, the thoughts, feelings and sensations that arise from moment to moment (Baer, 2003). It entails the ability to sustain attention on an intended point of focus and the ability to consciously switch attention to a new intended focus. Some meditation practices are methods designed to assist the practitioner in developing these attentional capacities. Placing the attention on the breath, on a fixed visual point, or on a mantra are all examples of attentional focus. As the mind wanders, the practitioner becomes aware of this, notes the thought process ("thinking"), and returns to the intended focus.

The second dimension of mindfulness, orientation to experience, concerns the attitude held towards one's present-moment experience, specifically one of curiosity, open-mindedness, and acceptance or non-judgment of whatever thoughts, feelings or sensations may arise (Baer, 2003).

MINDFULNESS-BASED PRACTICE IN OBH

Mindfulness-Based Practice and Emotion Regulation

Though the informal practice of mindfulness itself can have deep therapeutic benefits to emotional regulation, mindfulness-based practice has been formalized in mental health treatment as a specific modality of treatment. The primary mindfulness-based practices include Mindfulness-Based Cognitive Therapy (MBCT; Segal, Williams, & Teasdale, 2002), Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999), Dialectic Behavior Therapy (DBT; Linehan, 1993), and Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 1990). While the four therapies each have roots in Eastern philosophy and psychology, they are secular in nature. These practices have three components in common: mindfulness practice exercises, didactic instruction, and social support; however, these components have not been clearly differentiated in published studies when assigning cause to positive outcomes (Bishop, 2002). Though a full review of these practices is beyond the scope of this paper, it is important to understand how these practices positively impact emotion regulation.

Theorists have suggested that mindfulness-based practices may reduce symptoms of stress, anxiety and depression by modifying emotion regulation abilities, although it is unclear what specific mechanisms of change are enhanced by these practices (Chambers, Gullone, & Allen, 2009). It is theorized that mindfulness meditation promotes agents of change, which include a reduction in perseverative thoughts and rumination, increased metacognitive awareness, and an enhancement in attentional capacities through gains in working memory. Emotion regulation is thought to increase as a result of these cognitive gains (Corcoran, Farb, Anderson, & Segal, 2010). This may be due to the premise that emotion regulation refers to a range of strategies which may be implemented at varying points during an event or experience, including noting which emotions arise, how long they are sustained, and how they are experienced and expressed (Gross, 2007).

Gross' model of emotion regulation (1998) proposes five families of emotion regulation strategies, including situation selection, situation modification, attentional deployment, cognitive change, and response modulation. There is evidence that long-term mindfulness meditation practice may directly influence attentional deployment, specifically the ability to control negative repetitive thoughts (Ramel, Goldin, Carmona, & McQuaid, 2004), self-focused attention (Goldin, Ramel, & Gross, 2009), and the conscious placement and control of attention (Jha, Krompinger, & Baime, 2007).

Further supporting Corcoran, Farb, Anderson & Segal's (2010) hypothesis, research indicates that mindfulness meditation is negatively associated with rumination and is directly related to effective emotion regulation (Chambers, Lo & Allen, 2008). In particular, 20 nonclinical novice meditators who participated in a 10-day intensive mindfulness meditation retreat were compared to a wait-listed control group on mindfulness, rumination, affect and performance tasks for attention switching, sustained attention and working memory (Chambers, Lo & Allen, 2008). Following the meditation retreat, Chambers, Lo & Allen (2008) observed that the meditation group reported a higher level of dispositional mindfulness, less rumination, and a reduction in depressive symptoms than the control group. The meditation group displayed greater attentional control and an increased capacity for working memory during task completion than the control group.

Mindfulness training has similarly been demonstrated to decrease obsessive thought patterns, or rumination, among participants with chronic mood disorders. Participants in an 8-week MBSR training had significantly less reflective rumination compared to their initial rumination scores and to a control group matched to age, gender and symptomology. (Ramel, Goldin, Carmona, & McQuaid, 2004)

Regularly practicing mindfulness may allow elements of conscious and less conscious experience to be perceived from a non-personal, decontextualized and accepting stance. This provides the opportunity to disrupt reactivity (Broderick & Blewitt 2015), strengthen attention and bring behavior and problem solving under more conscious and reflective regulation. Mindfulness practice has been demonstrated to increase awareness on both the thinking and feeling level (Carmody & Baer, 2008), and thus contributes to a restoration of balance when strong emotions arise through metacognitive processes. Since emotions are transitory, it is useful to practice noticing emotions in the moment. Mindfulness practice offers the opportunity to develop resilience in the face of difficult feelings that may otherwise evoke a maladaptive behavioral response. By repeatedly orienting attention to a specific object or focus (the breath, bodily sensations, etc.) mindfulness practice strengthens attention while consciously letting go of distractions. Through this practice of intentionally sustained and focused attention, MBP

strengthens the executive skill of inhibition (Ramel, Goldin, Carmona, & McQuaid, 2004). Automatic processes may come under more conscious control, fostering reflective decision making and reducing impulsive reactions. The practice of orienting to experience with curiosity, patience, and non-judgment strengthens distress tolerance and may reduce the adolescent tendency to exaggerate perceived threat (Carmody & Baer, 2008), while providing a potential protective factor against stressors. Through the practice of accepting experience in the moment while being attentive to impulsive and automatic responses, resilience and emotion regulation can be strengthened and regulatory self-efficacy can be increased (Weijer-Bergsma, Formsma, Bruin, & Bogels, 2011).

Mindfulness and Adolescents

Although several randomized meta-analyses emphasize the efficacy of mindfulness-based therapies with adults (e.g., Baer, 2003; Grossman, et al. 2010; Hofmann, Sawyer, Witt, & Oh, 2010), studies of mindfulness training in adolescents are still in its infancy (Burke, 2009). The benefits of mindfulness on the alleviation of physiological concerns in adolescents has been reported (Black, Milam, & Sussman, 2009), with further findings that emotion regulation, along with non-attachment and rumination, mediated the effects of mindfulness on emotional distress (Coffey & Hartman, 2008). Mindfulness-based practices may also assist adolescents in responding with flexibility to changing environments or interactions (Brown, Ryan, & Creswell, 2007). Mindful adolescents are less likely to get caught up in dwelling on the past (rumination) or fixating on the future (worry). Ciarrochi, Kashdan, Leeson, Heaven, & Jordan (2010) suggest that adolescents who have the capacity to demonstrate experiential acceptance are more likely to self-regulate their emotional response to both pleasurable and non-pleasurable external events. Maladaptive behaviors such as aggression and procrastination may become impulsive automated responses to emotional distress (i.e. anger or anxiety), or perceptions of unpleasantness (i.e. boredom). Mindfulness is particularly suited to address these tendencies to respond in automatic, non-conscious ways to triggers. The practice of an attentive and nonreactive attitude toward one's impulses allows for responding with intention and awareness, and increases the 'gap' between impulse and action (Boyce, 2005).

Furthermore, it has been hypothesized that the level of mindfulness moderates psychological functioning and well-being in adolescents (Marks, Sobanski, & Hine, 2010), and has also been an effective way to capitalize on behavioral and emotional strengths (Wisner & Norton, 2013). According to a recent study by Parto and Besharat (2011), 717 adolescents (mean age 17.3) completed self-reports assessing mindfulness (Philadelphia Mindfulness Scale), emotional self-regulation (the Self-Regulation Inventory) and autonomy (the Autonomy Scale). The researchers found that as self-reported levels of mindfulness increased, psychological distress was reduced, including symptoms of anxiety and depression. The study further asserts that "the act and practice of mindfulness may help individuals decrease their emotional reactivity and use their body as a support and a primary warning gesture for recognition and refining of emotional and cognitive reactions...it improves psychological well-being by promotion of cognitive processes, reducing rumination, and improving self-regulation and self-awareness," (Parto & Besharat, 2011, p. 581).

Mindfulness has also been shown to reduce anxiety and stress among adolescents who were under current or recent outpatient care for psychiatric conditions (Biegel, Brown, Shaprio & Schubert, 2009), including youth with attention deficit hyperactivity disorder (ADHD; Weijer-Bergsma, Formsma, Bruin, & Bogels, 2011). In addition, this study reported that more time spent in sitting meditation practice predicted improved emotional functioning, as rated by clinicians blind to the treatment conditions. A 2011 study, Singh Singh & Singh found that mindfulness-based practice helped to reduce aggression among adolescents with Asperger's Syndrome. The sessions in this study consisted of a 10-point meditation designed to elicit a state of somatic calmness, even while envisioning scenes that would have elicited an aggressive response in the past. Bogels, Hoogstad, van Dun, Schuttler & Restifo (2008) discovered that after combined mindfulness training for the adolescents (age 11-18) and their parents in concurrent mindfulness-based cognitive therapy groups, the parents reported direct and longer-term improvements in adolescents' externalizing behaviors and attention problems, self-control, and attunement to others, and adolescents themselves reported large improvements on their own goals and symptoms (Bogels , Hoogstad, van Dun, Schuttler & Restifo, 2008).

MINDFULNESS-BASED PRACTICE IN OBH

Mindfulness-Based Practice in Outdoor Behavioral Healthcare

Outdoor Behavioral Healthcare (OBH) can be defined as a type of outdoor adventure therapy which includes "the prescriptive use of adventure experiences provided by mental health professionals, often conducted in natural settings that kinesthetically engage clients on a cognitive, affective and behavioral level" (Gass, Gillis & Russell, 2012, p. 1). Wilderness therapy, adventure therapy, equine-assisted therapy, challenge courses, and similar programs may all fall under the definition of an OBH program, provided they operate as licensed mental health or substance abuse programs staffed by licensed clinicians. OBH provides services to youth, young adults and families, and addresses a variety of clinical issues. Research has demonstrated OBH to be an effective intervention for improving self-concept, social skills, substance abuse, recidivism, depression, and youth and family functioning (Gass, Gillis & Russell, 2012; Harper, Russell, Cooley, & Cupples, 2007; Norton, 2010; Norton, et al, 2014).

The role of stillness and quiet has been documented in helping facilitate deeper human/nature connections (Nicholls & Gray, 2007). In order to do so intentionally in a therapeutic outdoor setting, Norris (2011) encouraged wilderness programs to use ritual mindfully to assist clients in being fully conscious in the moment in order to unpack the meaning of these experiences and how they transfer to life. However, despite the unique intersection of the present-focused and experiential nature of OBH with the awareness focus of mindfulness-based practice, only a few studies have been conducted which explore the specific efficacy of mindfulness-based practice in OBH settings. In a mixed-methods study, Wallis (2012) investigated the effectiveness of wilderness therapy in promoting mindfulness, self-esteem, psychological health, and improving emotional, behavioral and relational symptoms. Results indicated clinically significant change, as participants' mindfulness and self-esteem scores moved from the dysfunctional to the functional range during wilderness therapy. Similarly, the OBH program under investigation in Bettmann, Russell & Parry's (2013) study, used mindfulness practices, such as meditation and yoga, to help students develop emotional awareness and regulation skills. Though these program variables were not directly controlled for, the overall outcomes of the study showed that the OBH program was effective in helping clients utilize abstinence-focused coping skills such as contacting a sponsor or asking for help from loved ones. The authors of the study posited that this may have been a result of the youth developing greater awareness of their emotions and the ability to manage them, which then allowed them to ask for help (Bettmann et al., 2013).

The most definitive study to date on mindfulness-based practice in OBH examined the role of mindfulness and adventure on treatment outcomes in substance abuse for young adult males. Quantitative data in this mixed-methods study showed statistically significant increases in mindfulness as measured by the Five Facet Mindfulness Questionnaire (FFMQ) from pre- to post-treatment, as well as a significant correlation between mindfulness skills and positive treatment outcomes (Russell, Gillis & Heppner, 2016). Qualitative data from this study further affirmed the need for mindfulness in OBH programs, especially as it relates to addictions treatment. Despite these few promising studies, it is unknown to what extent mindfulness-based practice is being utilized in OBH. To this end, this survey research study explores the prevalence and types of mindfulness-based practices currently being utilized in OBH programs.
The study sought to address the following areas of inquiry:

- Is mindfulness-based practice currently being utilized in OBH treatment settings, and if so to what degree?
- What is the perceived effectiveness of mindfulness-based practice in addressing primary treatment goals of adolescent clients, particularly emotion regulation?
- What are the specific mindfulness-based practice skills and practices are being incorporated by OBH programs?
- What is the training and experience of staff members providing mindfulness-based practice in treatment?

Methods

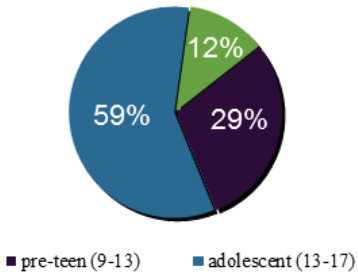
The study utilized survey research methods to gather data regarding the prevalence and type of mindfulness-based practice used in OBH programs. Survey Monkey was used to develop an online survey with questions about program demographics, such as clients served, length of stay and clinical issues addressed. Questions about the types of mindfulness-based practices used were based on a

review of the literature, and followed Streiner & Norman's guidelines (2003) of survey development to ensure face and content validity, internal consistency and reliability. Surveys were pilot-tested with a group of OBH programs that were then not included in the actual survey. Feedback was gained from these programs to enhance the quality of the survey.

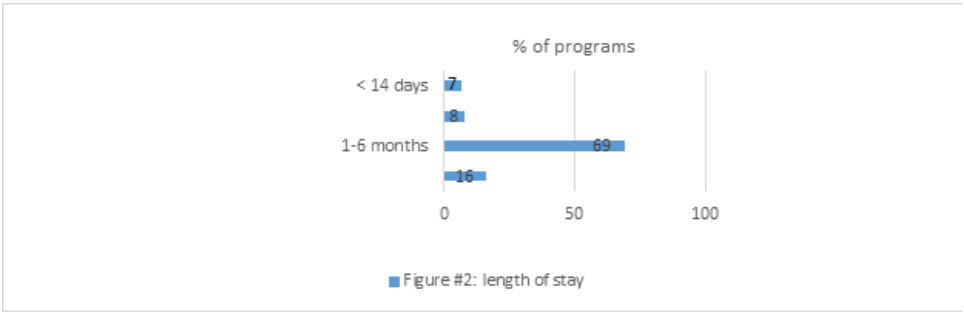
Once the survey was finalized, a non-probability, purposeful sample of 25 OBH programs were surveyed online. The survey was sent to and completed by OBH staff that provided mental health and therapeutic services to OBH clients. Of the 25 surveys sent, staff from 14 OBH programs responded to the survey, for a response rate of 56%.

Programs were assessed for their client population, primary treatment focus, length of stay, and gender mix. The surveyed facilities were evenly mixed between residential and community-based programs. In identifying their primary treatment population, Figure 1 shows that 38.5% served pre-teens (9-13 years old), 76.9% served adolescent clients (13-17 years old), 53.8% served young adults (24 or older), while 15.4% served adult clients. As a number of facilities offer multiple treatment programs that address differing age groups, there was significant overlap amongst age groups. Thirty percent augmented their course of treatment with an active family counseling component. In reporting gender populations, only six programs responded to this question, with the majority (39%) reporting a mixed gender population.

Figure #1 Client age range



Client length of stay varied from seven days to greater than six months. Figure 2 shows that the majority of programs utilized a program length of six months or less (69.2%), while

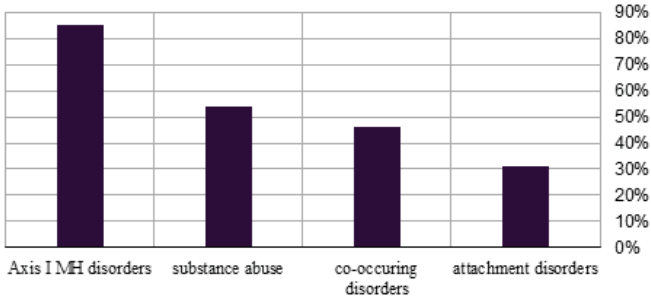


15.4% extended beyond six months. Eight percent of programs were shorter term, one month or less.

The vast majority of OBH programs surveyed (85%) reported a primary treatment focus of Axis I mental health conditions, including mood disorders, anxiety disorders, eating disorders and attentional challenges; 53% describe substance abuse as a primary focus; co-occurring

disorders (mental health and substance abuse) comprise 47% of program focus, with 30% addressing attachment disorders as their program specialization (see Figure 3).

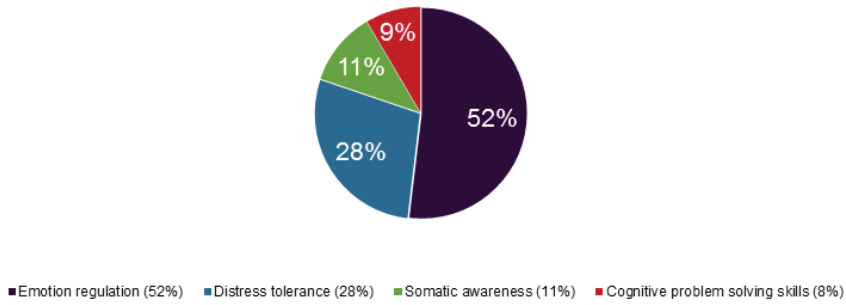
Fig. #3 Primary treatment focus



Results

Results from this exploratory study show that mindfulness-based practice is being utilized in both residential and community-based OBH programs. The results demonstrate that 100% of participating programs utilize mindfulness-based practice as an 'active component of treatment.' However, 84.6% of the programs surveyed report using it 'randomly.' Only 15.4% of OBH programs report that components of mindfulness-based practice are included in actual documented treatment planning. While the large majority of surveyed programs do not incorporate mindfulness-based practice as a manualized or structural component of treatment, 68% of OBH professionals surveyed report mindfulness-based practice to be an effective therapeutic tool in supporting treatment goals for their clients. Figure 4 highlights the four most common treatment goals reported by OBH staff which are

Fig. #4 OBH treatment goals enhanced by MBP

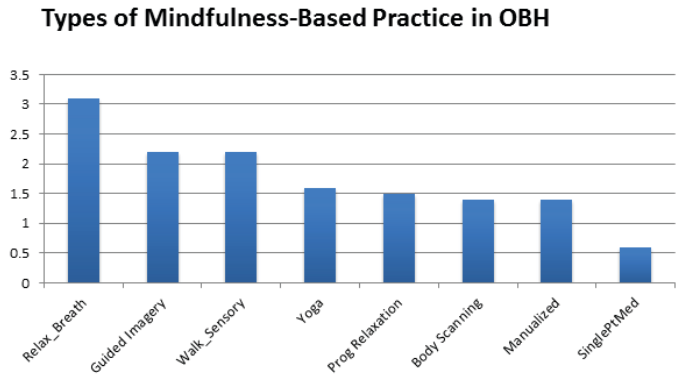


perceived to benefit from mindfulness-based practice, the most commonly cited being emotion self-regulation (52%).

Of the specific mindfulness components utilized in their programs, survey respondents identified relaxation breathing (85%), guided imagery meditation (69%), walking or sensory meditation (69%), progressive bodily relaxation (48%), single pointed meditation (38%), yoga (38%), body scanning (30%), and loving-kindness meditation (7%) as the primary practices

used with clients. Figure 5 illustrates the types of mindfulness-based practices being utilized, in order of prevalence:

Figure #5. Types of Mindfulness-Based Practices Utilized in OBH



While programs surveyed reported using mindfulness-based practices in their programs, only 38.5% of OBH staff reported to have received specific, formal training in these practices. The remainder of OBH staff described gaining knowledge via the following sources:

- Personal experience or meditation practice
- Professional conferences
- Graduate school
- Personal research (books/articles)

Implications

Mindfulness-based practice has become an increasingly important component in the OBH treatment process. By definition, OBH programs utilize experiential, somatic, and process oriented modalities to support adolescent and young adult clients in their return to mental and emotional health. As such, mindfulness-based practices have been adopted by 100% of surveyed OBH programs, and is reported to positively assist clients with a wide range of treatment goals, including emotion regulation, cognitive problem-solving skills, somatic awareness, and distress tolerance. Sixty-eight percent of programs surveyed believe mindfulness-based practice to be an effective therapeutic tool, which by any measure could be identified as an efficacious mode of treatment with positive treatment outcomes. However, a large percentage of mindfulness treatment delivery in the surveyed programs is randomly implemented by staff who are not formally trained. This may be ineffective at best, and problematic at worst. As mindfulness-based practice continues to be adopted as part of a holistic and experiential treatment experience, further assessment of training and standardization of treatment delivery is warranted, while avoiding stripping the essence of mindfulness (experiential and intrapersonal) in the service of homogenization and manualized treatment.

Limitations and Areas for Future Research

Though this study begins to shed light on the prevalence and type of mindfulness-based practice being utilized in OBH, it is important to note that these findings are limited due

to the small sample size and may not be reflective of all OBH programs. Likewise, these findings are based only on subjective self-reports of OBH program staff, and are not tied to improvements in actual client outcomes. Future research needs to continue to examine the impact of mindfulness-based practice on clients' emotional and behavioral functioning in OBH programs. Likewise, the current research base is limited by the lack of empirical evidence confirming the efficacy of these interventions on younger populations. Future research would benefit from continued exploration of one specific type of mindfulness-based practice, specifically attuned to the developmental needs of adolescents. As a rapidly emerging field of study, research in mindfulness practices in general would benefit from true randomized samples by condition of sufficient size to generalize findings and allow for group differences. As the neural basis for varying levels of emotional regulation and physiological response to cognition continues to be explored in adult studies, the utilization of imaging technology such as functional magnetic resonance imaging (fMRI) or other concrete interpretive data would also be a beneficial addition in the study of OBH adolescent clients participating in mindfulness-based practice.

Conclusion

Mindfulness-based practice has been demonstrated to yield real and lasting benefits during adolescence and beyond by providing tools for reducing stress and fostering wellness (Burke, 2009). Mindfulness-based practice has the documented capacity to aid the healthy development of self-awareness, self-regulation and emotional balance (Hofmann, Sawyer, Witt, & Oh, 2010), allowing adolescents to adapt to their environment and relationships with resilience. The application of mindfulness-based practice in OBH certainly has promise, yet the question of specificity in mindfulness interventions with adolescents deserves further study across interventions. It is likely that even "pure" mindfulness interventions (such as MBSR) contain cognitive, behavioral, and psycho-educational components (Bishop et al., 2004). Given the stated hypothesis of the majority of studies that mindfulness is central to psychological well-being, it will be important to discern if mindfulness can be cultivated only through mindfulness training, or if adolescents can also learn to respond in mindful ways to their emotions through other forms of therapy (Chambers, Gullone, & Allen, 2009). As the prevalence of psychological concerns continues to increase in the adolescent population, innovative and evolving strategies in OBH, including mindfulness-based practices, are required to respond to the escalating

References

Andersen, S. L., & Teicher, M. H. (2008). Stress, sensitive periods and maturational events in adolescent depression. *Trends in Neuroscience, 31*(4), 183–191.

Arnsten, A. F. T., & Shansky, R. M. (2004). Adolescent vulnerable period for stress-induced prefrontal cortical function. *Annals of the New York Academy of Sciences, 1021*(1), 143–147.

Baer, R. A. (2003). Mindfulness training as a clinical intervention: a conceptual and empirical review. *Clinical Psychology: Science and Practice, 10*(2), 125–143.

Bettmann, J. E., Russell, K. C., & Parry, K. J. (2013). How substance abuse recovery skills, readiness to change and symptom reduction impact change processes in wilderness therapy participants. *Journal of Child and Family Studies, 22*(8), 1039-1050.

Biegel, G. M, Brown, K. W., Shapiro, S. L, & Schubert, C. (2009). Mindfulness-based stress reduction for the treatment of adolescent psychiatric outpatients: A randomized clinical trial. *Journal of Clinical and Consulting Psychology, 77*(5), 855-866.

Bishop, R. S. (2002). What do we really know about mindfulness-based stress reduction? *Psychosomatic Medicine, 64*(1), 71-83.

Bishop, S. R., Lau, M. A., Shapiro, S. L., Carlson, L., Anderson, N. D., Carmody, J., Devins, G. (2004). Mindfulness: A proposed operational definition. *Clinical Psychology, 11*(3), 230-241.

Black, D. S., Milam, J., & Sussman, S. (2009). Sitting meditation interventions among youth: a review of treatment efficacy. *Pediatrics, 124*(3), 532–541.

Bodhi, B. (2000). *A comprehensive manual of Adhidhamma*. Seattle: BPS Pariyatti.

Bögels, S., Hoogstad, B., van Dun, L., de Schutter, S., & Restifo, K. (2008). Mindfulness training for adolescents with externalizing disorders and their parents. *Behavioural and Cognitive Psychotherapy, 36*(02), 193-209.

Boyce, B. (2005). Two sciences of the mind. *Shambhala Sun, 13*(34–43), 93–96.

Broderick, P. C., & Blewitt, P. (2015). *The life span: Human development for helping professionals* (4th ed.). Upper Saddle River, NJ: Pearson Education.

Brown, K. W., Ryan, R. M., & Creswell, J. D. (2007). Mindfulness: theoretical foundations and evidence for its salutary effects. *Psychological Inquiry, 18*(4), 211–237.

Burke, C. A. (2009). Mindfulness-based approaches with children and adolescents: a preliminary review of current research in an emerging field. *Journal of Child and Family Studies, 19*(2), 133– 144.

Carmody, J., & Baer, R. A. (2008). Relationships between mindfulness practice and levels of mindfulness, medical and psychological symptoms and well-being in a mindfulness-based stress reduction program. *Journal of Behavioral Medicine, 31*(1), 23–33.

Caspi, A., Henry, B., McGee, R. O., Moffitt, T. E., & Silva, P. A. (1995). Temperamental origins of child and adolescent behavior problems: from age three to age fifteen. *Child Development, 66*(1), 55–68.

Chambers, R., Lo, B. C. Y., & Allen, N. B. (2008). The impact of intensive mindfulness training on attentional control, cognitive style, and affect. *Cognitive Therapy and Research, 32(*2), 303–322.

Chambers, R., Gullone, E., & Allen, N.B. (2009). Mindful emotion regulation: An integrative review. *Clinical Psychology Review, 29*(6), 560–572.

Ciarrochi, J., Heaven, P. C. L., & Supavadeeprasit, S. (2008). The link between emotion identification skills and socio-emotional functioning in early adolescence: a one-year longitudinal study. *Journal of Adolescence, 31*(5), 565–582.

Ciarrochi, J., Kashdan, T., Leeson, P., Heaven, P., Jordan, C. (2010). On being aware and accepting: A one-year longitudinal study into adolescent well-being. *Journal of Adolescence, 34*(4), 659-703. doi: 10.1016/j.adolescence.2010.09.003

Cisler, J. M., Olatunji, B. O., Felder, M. T., & Forsyth, J. P. (2010). Emotion regulation and the anxiety disorders. *Journal of Psychopathology and Behavioral Assessment, 32*, 68–82.

Coffey, K. A., & Hartman, M. (2008). Mechanisms of action in the inverse relationship between mindfulness and psychological distress. *Complementary Health Practice Review, 13*(2), 79–91.

Cooper, L. M., Wood, P. K., Orcutt, H. K., & Albino, A. (2003). Personality and the predisposition to engage in risky or problem behaviors during adolescence. *Journal of Personality and Social Psychology, 84*(2), 390–410.

Cooper, M. L., Russell, M., Skinner, J. B., Frone, M. R., & Mudar, P. (1992). Stress and alcohol use: moderating effects of gender, coping, and alcohol expectancies. *Journal of Abnormal Psychology, 101*(1), 139–152.

Corcoran, K. M., Farb, N., Anderson, A., & Segal, Z. V. (2010). Mindfulness and emotion regulation. Outcomes and possible mediating mechanisms. In A. M. Kring & D. M. Sloan (Eds.), *Emotion regulation and psychopathology: A transdiagnostic approach to etiology and treatment* (pp. 339 –355). New York: Guilford Press.

Davis, T. E., May, A., & Whiting, S. A. (2011). Evidence-based treatment of anxiety and phobia in children and adolescents: current status and effects on the emotional response. *Clinical Psychology Review, 31*(4), 592–602.

Eisenberg, N., Spinrad, T. L., & Eggum, N. D. (2010). Emotion-related self-regulation and its relationship to children's maladjustment. *Annual Review of Clinical Psychology, 6*, 495–525.

Farrell, A. D., & Danish, S. J. (1993). Peer drug associations and emotional restraint: causes or consequences of adolescents' drug use? *Journal of Consulting and Clinical Psychology, 61*(2), 327–334.

Gass, M., Gillis, H. L., Russell, K. C. (2012). *Adventure therapy: Theory, research, and practice*. New York: Routledge.

Goldin, P., Ramel, W., & Gross, J. J. (2009). Mindfulness meditation training and self-referential processing in social anxiety disorder: Behavioral and neural effects. *Journal of Cognitive Psychotherapy, 23*, 242–257.

Gross, J. J. (1998). The emerging field of emotion regulation: An integrative review. *Review of General Psychology, 2*, 271–299.

Gross, J. J. (Ed.). (2007). *The handbook of emotion regulation*. New York: Guilford Press.

Grossman, P., Kappos, L., Gensicke, H., D'Souza, M., Mohr, D.C., Penner, I.K., & Steiner, C. (2010). MS quality of life, depression, and fatigue improve after mindfulness training: A randomized trial. *Neurology, 75(*13), 1141–1149.

Gunaratana, H. (2002). *Mindfulness in plain English*. Somerville, MA: Wisdom Publications.

Harper, N., Russell, K. C., Cooley, R., & Cupples, J. (2007). Catherine Freer Wilderness Therapy Expeditions: An exploratory study of adolescent wilderness therapy, family functioning, and the maintenance of change. *Child and Youth Care Forum, 36*(2-3), 111-129.

Hayes, S. C., Strosahl, K., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guilford.

Hofmann, S. G., Sawyer, A. T., Witt, A. A., & Oh, D. (2010). The effect of mindfulness-based therapy on anxiety and depression: a meta-analytic review. *Journal of Consulting and Clinical Psychology, 78*(2), 169–183.

Jha, A. P., Krompinger, J., & Baime, M. J. (2007). Mindfulness training modifies subsystems of attention. *Cognitive Affective and Behavioral Neuroscience, 7*, 109–119.

Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain and illness*. New York: Delacorte.

Kabat-Zinn, J. (1994). Wherever you go, there you are: *Mindfulness meditation in everyday life*. New York: Hyperion.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guildford Press.

Lutz, A., Slagter, H. A., Dunne, J. D., & Davidson, R. J. (2008). Attention regulation and monitoring in meditation. *Trends in Cognitive Sciences, 12*, 163–169.

Marks, A. D. G., Sobanski, D. J., & Hine, D. W. (2010). Do dispositional rumination and/or mindfulness moderate the relationship between life hassles and psychological dysfunction in adolescents? *The Australian and New Zealand Journal of Psychiatry, 44*(9), 831–838.

Merikangas KR, He J, Burstein M, Swanson SA, Avenevoli S, Cui L, Benjet C, Georgiades K, Swendsen J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Study-Adolescent Supplement (NCS-A). J Am Acad Child Adolesc Psychiatry, 49(10):980-989.

Nicholls, V., & Gray, T. (2007). The role of stillness and quiet when developing human/nature relationships. *Australian Journal of Outdoor Education, 11*(1), 21.

Norris, J. (2011). Crossing the threshold mindfully: exploring rites of passage models in adventure therapy. *Journal of Adventure Education & Outdoor Learning, 11*(2), 109-126.

Norton, C.L. (2010). Exploring the process of wilderness therapy: Key therapeutic components in the treatment of adolescent depression and psychosocial development. *Journal of Therapeutic Schools and Programs, 4*(1), 24-46.

Norton, C.L., Tucker, A., Russell, K., Bettman, J., Gass, M., Gillis, H.L., & Behrens, E. (2014). State of knowledge: Adventure therapy with youth. *Journal of Experiential Education, 37*(1). DOI: 10.1177/1053825913518895

Parto, M., & Besharat, M. (2011). Mindfulness, psychological well-being and psychological distress in adolescents: Assessing the mediating variables and mechanisms of autonomy and self-regulation. *Social and Behavioral Sciences, 30*, 578-582.

Penza-Clyve, S., & Zeman, J. (2002). Initial validation of the Emotion Expression Scale for Children (EESC). *Journal of Clinical Child and Adolescent Psychology, 31*(4), 540–547.

Raffaelli, M., & Crockett, L. J. (2003). Sexual risk-taking in adolescence: the role of self-regulation and risk-proneness. *Developmental Psychology, 39*(6), 1036–1046.

Ramel, W. Goldin, P. R., Carmona, P. E., & McQuaid, J. R. (2004). The effects of mindfulness meditation on cognitive processes and affect in patients with past depression. *Cognitive Therapy and Research, 28*, 433–455.

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.

Saarni, A. (1999). *The development of emotional competence*. NY: Guilford Press.

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. New York: Guilford Press.

Siegel, D. J. (2007). *The mindful brain: Reflection and attunement in the cultivation of well-being*. New York: Norton.

Singh, N., Lancioni, G., Singh, A., Winton, A., Singh, J. (2011). Adolescents with Asperger syndrome can use a mindfulness-based strategy to control their aggressive behavior. *Research in Autism Spectrum Disorders, 5*(3), 1103-1109

Streiner, D.L. & Norman, G.R. (2003). *Health measurement scales: A practical guide to their development and use* (3rd ed). New York, NY: Oxford University Press.

Valentine, E. R., & Sweet, P. L. G. (1999). Meditation and attention: A comparison of the effects of concentrative and mindfulness meditation on sustained attention. *Mental Health Religion & Culture, 2*, 59–70.

Wallis, V. (2012). *A mixed method evaluation of a wilderness therapy programme for" youth at risk"* (Doctoral dissertation, University of Essex).

Walsh, R., & Shapiro, S. L. (2006). The meeting of meditative disciplines and western psychology: A mutually enriching dialogue. *American Psychologist, 61*, 227–239.

Watanabe, N., Hunot, V., Omori, I. M., Churchill, R., & Furukawa, T. A. (2007). Psychotherapy for depression among children and adolescents: a systematic review. *Acta Psychiatrica Scandinavica, 116*(2), 84–95.

Weijer-Bergsma, E., Formsma, A., Bruin, E., Bogels, S. (2011). The effectiveness of mindfulness training on behavioral problems and attentional functioning in adolescents with ADHD. *Journal of Child and Family Studies, 21*(5). doi:10.1007/s10826-011-9531-7

Wisner, B. L. & Norton, C. L. (2013). Capitalizing on behavioral and emotional strengths of alternative high school students through group counseling to promote mindfulness skills. *Journal for Specialists in Groupwork, 38*(3), 207–224. doi: 10.1080/01933922.2013.8035

Family Team Dynamics: An Intervention for Enhancing Reflective Functioning in Direct Care Staff in Children's Residential Relational Treatment

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Intermountain

Abstract

Research on evidence-based practices consistently finds that the therapeutic relationship accounts for as much of the variance toward successful outcomes as any particular intervention. Self-awareness and self-reflection are critical practices to enhance the therapeutic relationship and ensure that the clinician is maximizing the accuracy of attunement with the client. Yet in relationally-oriented milieu treatments, those that have the most contact with and impact upon the children – the direct care staff – may have the least training and the least opportunity for self-reflection. Family Team Dynamics is a group process for those working directly with children that was created by Intermountain and has been in continual use for 18 years. The goals of this process are to enhance self-awareness, develop team cohesion, improve peer to peer supervision and create a healthy, therapeutic culture. The result, by staff's report, is a growth producing experience from which staff can better understand one another, support one another in tough situations, and better attune with the children, families and one another. Staff from this residential program rate supervision, guidance and learning as high, and have low turnover and high tenure compared to similar agencies working with seriously emotionally disturbed youth in residential care.

Keywords: attunement, self-reflection, residential treatment, children, group process

Research on evidence-based practices consistently finds that the therapeutic relationship accounts for as much of the variance toward successful outcomes as any particular intervention. In Norcross' (2013) meta-analysis of the efficacy of therapy interventions, he noted that "the answer (is) obvious, and empirically validated. As a general trend across studies, the largest chunk of outcome variance not attributable to preexisting patient characteristics involves individual therapist differences and the emergent therapeutic relationship between patient and therapist, regardless of technique or school of therapy. This is the main thrust of three decades of empirical research. (p. 15)"

Self-awareness and self-reflection are critical practices to increase the accuracy of attunement (Perez, 2011; Siegel & Hartzell, 2003) and thereby to enhance the therapeutic relationship (Fonagy & Target, 1997; Schore, 2009). Self-reflection involves the exploration of one's own motivations and emotions in reaction to and in the presence of one's clients. Self-reflection has been shown to decrease burnout in complex, emotionally charged therapeutic situations, to increase a sense of efficacy and even to contribute to positive therapeutic outcomes (Bloom, 2014; Davies & Collings, 2008; Urdang, 2010). Self-awareness is the in-the-moment observation of significant departures from "being with" clients. The majority of studies demonstrating the positive impact of increasing self-reflection and self-awareness involve professionals, for example, psychiatric nurses or master's level trained psychotherapists (Cahill et al., 2004; Davies & Collings, 2008; Gatti &Watson, 2011).

A review of interventions intended to improve morale and patient outcomes (Cahill et al., 2004) noted that regular psychosocial and psychological interventions with mental health staff were more effective in reducing burnout than educational, environmental or process changes. Other studies with nurses in infant mental health (e.g., Gatti & Watson, 2011) have provided anecdotal evidence that self-reflective practice enhanced the sense of efficacy of staff, reduced burnout and improved patient outcomes. In this study, successful self-reflective group processes were regular and included time that was specifically set aside for such processing.

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FAMILY TEAM DYNAMICS

The irony for those of us providing residential treatment for children is that the very staff who have the most contact and often deepest relationships with youth are those with the least amount of training and time for improving their therapeutic alliances – direct care staff. Direct care staff typically have high rates of burnout, creating high turnover, reduced tenure and less stability in these critical positions (Dickinson & Painter, 2009; Paris & Hoge, 2010). In order to provide an opportunity to enhance self-reflection in the very important work of providing care for the "other 23 hours" (Fahlberg, 1990) outside of the one hour of weekly therapy, a children's residential program in the western United States has created a dedicated time for direct care staff to examine their interactions with children and with each other, supported by their supervisor and the therapist in their team. The program serves children, ages 4 – 14, and has an average treatment duration of 15 months.

The treatment agency calls this process "Family-Team Dynamics" or FTD. FTD is a weekly group process in which a therapeutic residential unit, comprised of direct care staff, the direct care supervisor and the therapist, engage in introspection and exploration, not about the children's lives, but about their own lives and their own relationships, with the children, the children's families, with one another. The intent is to enhance the use of self-reflection to improve the effective use of self with children and families. This simple task increases empathy for the children and their families, and has had long-term effects of building team cohesion and reducing turnover. It is "on the job training" for direct care staff in leading milieu groups and phrasing interventions and observations with children and families carefully, thoughtfully and respectfully.

You Can't Take a Child Where You Can't Go

To understand the value of self-reflection for staff in this program, it is helpful to first understand the program's developmental/relational approach that has been developed over past decades (Kohlstaedt, 2010). We provide residential treatment for young (age 6- 14), emotionally disturbed children. Milieu staff form intentionally psychologically intimate relationships with children who are emotionally disturbed. The therapeutic instruments of the milieu staff are attunement and empathy for the child and family. The goal of that attunement is to build the reflective functioning of the child and of the family (Bleiberg, 2001); that is, the ability to reflect on one's own inner world and to understand and incorporate the inner world of the other as reflections of the self. This mimics the task of the good enough parent in building a child's sense of self (Bleiberg, 2001; Mahler, Pine, & Bergman, 1975; Sroufe & Waters, 1977). For many of the children served in our program, adequate parental reflection was lacking due to the child's early life in an orphanage, sensory or cognitive impairment of the child, or the emotional disturbance and/or emotional unavailability of the parent. Whatever the underpinning for the lack of attunement, neither the child nor the parent can advance until he "feels felt," (Siegel, 2003); i.e., understood by significant others. Yet, attunement with a child who consistently "miscues" (Hoffman, Marvin, Cooper, & Powell, 2006) is difficult, if not overwhelming; so much so that parents may not be able to build their child's reflective capacity on their own. Thus, the task of attunement falls to the residential staff who can identify the child's needs, reflect those needs, meet them and then help the child articulate the needs clearly so that the parent can address them. As a result of the therapeutic "metabolization" of needs and affect (Fosha, 2000), the child begins to co-regulate with the adult so that, in Daniel Siegel's (2003) words, the child "feels felt."

This approach requires staff to "be someone for the child, not do something to the child" (FitzGerald, 2015). Direct care staff reflect the child's inner world- usually of pain, shame and loss - as demonstrated in behavior, emotions and relationships, and this leads the child to experience himself as different within the new relationships with staff. The therapeutic benefit of accurate attunement and experiencing self as psychologically held is not a new concept. It is the foundation of short-term dynamic therapy and dyadic developmental therapy for children. (Fosha, 2000; Hughes, 1997). It is new, however, to the world of direct care staff interventions. In our experience, without this holding environment in the milieu, children don't feel safe enough to explore what they need to in psychotherapy.

If staff have their own childhood wounds, they may steer the child away from the inner pain rather than being able to "hold" it psychologically. As noted in Stapleton, Young and Senstock's research (2016), staff may experience secondary stress if their form of coping with a child's stress is avoidance or emotional coping. If they haven't integrated their own depression, loss or trauma, then they can't psychologically hold a child as he begins to go to those dark places. It is vital that staff become aware of their own psychological pain so that they don't unconsciously project that pain onto the child or

avoid the child's pain in an unconscious effort to protect themselves. The unconscious projection of unintegrated affect or avoidance of another's pain has been used to explore and explain less than optimal relationships between mother and infant (Main & Hesse, 1990; Spitz, 1951). By extension, those with healing relationships may be subject to the same unconscious projection, preventing optimal healing relationships in treatment. In providing emotionally corrective experiences for children in residential care, this agency feels that it is vital for residential direct care staff to have an understanding of these barriers and to examine them. FTD helps staff, through reflection by colleagues, become aware of their own issues. The goal is that by experiencing support and attunement with colleagues the staff have increased ability to attune to the children.

Helping the Child "Feel Felt"

Most of our college educated direct care come from related fields of sociology or psychology, but some may come from backgrounds of business or zoology or accounting. Even those with psychology degrees may have knowledge of theory but no training or awareness of how actually to attune to children. Very few direct care staff have been in psychotherapy and have little idea what it feels like to have someone attune to their inner experience. Family Team Dynamics lets staff experience what it feels like to have someone gently guide them into increased self-awareness. The expectation is that recognition of their own vulnerability within FTD makes them more sensitive to the child's and family's experience of vulnerability and can increase their compassion for the hard work that therapy is for children and families.

It Takes a Village

Residential milieus can provide a powerful re-education in living by giving the distressed child a new and healthier experience of himself. But they are also subject to a plethora of problems that accompany treatment of emotionally disturbed youth and families (Olive, 2006; Bloom, 2014). In our experience, direct care staff can become split into warring factions as the child projects his own internal split onto the staff. We have observed individual staff become triggered by particular children and treat them overly harshly or overly indulgently. Children in residential care may elicit triangulation as staff align with the child against the parents. This last dynamic was one at play frequently before this agency began the FTD process.

We have found that our milieu has become more effective and therapeutic when all observations are valuable and valid, and the team works through conflicts with an eye to interdependency and interpersonal trust and clarity. This creates the "sanctuary" in which optimal treatment can occur (Bloom, 2014). In our experience, the most effective treatment teams are ones in which individual staff rely on their work partners to see what they don't see, to help them organize the children psychologically and to support each other when they are struggling personally or professionally. Just as understanding a child's background can increase staff's understanding of why the child behaves as he does, so understanding teammates' backgrounds helps the staff support one another and build cohesion among the team. FTD is a way to build cohesion among team members and draw attention to dynamics that may be being provoked by individual pathology.

The FTD Process

We have found the selection of the *right* staff to be the foundation for a healthy, self-aware treatment team who can psychologically hold emotionally distressed children. In interviews for direct care positions, the applicant is asked to think about any unresolved issues that might be triggered by children. Supervisors are not looking for specific historical information, but rather a self-curiosity that can be tapped and guided when the going gets tough. Interviewers are explicit about the group structure of FTD and that it is a requirement of the position. The job description for direct care staff includes a requirement that the staff is open to feedback and is curious about his own internal workings. Of course, most direct care staff don't know how they'll respond until they get into the FTD process itself, but as they watch their more senior colleagues explore, and help others explore, they begin to experience safety rather than threat.

FTD is leaderless in the sense that all members – including supervisors and therapists– are expected to participate equally. This is a forum in which direct care may be able to confront the supervisor

(gently and with curiosity) about observed unavailability to staff, or confront the therapist (gently and with curiosity) about perceived avoidance of engaging a particular family. Although FTD is leaderless in the equality of expectation for sharing, the therapist is typically responsible for initially pointing out group dynamics such as scapegoating, sub-grouping or boundary violations. The therapist and supervisor may model safe self-disclosure by being the first to share their own life story. Senior direct care staff model sensitive ways of giving feedback to other team members and respectful ways to resolve conflict. Therapist, supervisor and senior direct care staff model curiosity about self and others.

FTD begins as most groups, with explicit stating of rules and boundaries: commitment for regular attendance, confidentiality except under conditions of harm to self or others and that information shared in FTD cannot be used in disciplinary, personnel or administrative matters. Participants are encouraged to start slowly and be careful with wording in providing feedback to others, ensuring that words and reflections are joining rather than alienating. For a group just starting an FTD process, it may be helpful to start with either genograms or structured questions about family background as are found in Siegel and Hartzell (2003). Examples of starting question for all members are:

- "How have your childhood experiences influenced your relationship with others as an adult?
- Do you find yourself trying not to behave in certain ways because of what happened to you as a child?
- Do you have patterns of behavior that you'd like to alter but have difficulty changing?"
- "How did your parents communicate with you when you were happy and excited? Did they join with you in your enthusiasm?
- When you were distressed or unhappy as a child, what would happen? Did your father and mother respond differently to you during these emotional times? How?" (Siegel & Hartzell, 2003).

Groups can also start by having each member give their family of origin transcribed by the therapist onto a genogram.

Fears and Opportunities

Our agency has used FTD for nearly 2 decades without administrative or personnel violations. Nonetheless, other agencies and staff are sometimes frightened by the prospect of an insight oriented group for direct care that has direct supervisors as members of the group. As noted above, participation in FTD is made explicit in the interview and staff selection process, and prospective staff can self-select out at any point. While attendance at FTD is a requirement of the position, participation is not, so that if someone is uncomfortable sharing, s/he may remain silent. Our experience is that those who do remain silent eventually become comfortable sharing at their own comfort level as their confidence grows. Information obtained in FTD cannot be used to terminate, although information which comprises a risk to self or others may be reported and dealt with through mandatory reporting laws deal with it within FTD or within their own therapy.

FTD puts interpersonal conflicts on the table so that conflicts do not get acted out with children; staff support and confront other staff so that supervision is not only top down, but peer to peer. We believe that this is vital in an active milieu with emotionally disturbed children. No agency is immune to the harm that unsupervised staff can wreak on distressing children, and the more eyes that we have on one another, and the more accountability to each other, the better in our experience. FTD may mix personal and professional boundaries, but the program believes that it is better to know that a colleague is, for example, stressed and grumpy because he is going through a divorce than to assume that he is just being a "jerk".

A fear expressed by other agencies is that FTD may provide a venue for complaining about the "outgroup", e.g., administration, and thereby cement negativity and foment rebellion, but the encouragement by therapist, supervisor and senior direct care is to look within as one can change only oneself; a limit that comes from within the group. Some staff find the vulnerability of talking about feelings frightening, but it is critical for them to feel that fear honestly so that they can deal respectfully and empathically with the children and families who come for care and who are also afraid.

Case Examples

Two examples illustrate the impact of FTD on treatment. All identifying information has been changed and identities have been obscured. The staff alluded to provided permission to use these examples when they were active staff members.

Case 1: In the FTD process, a male staff who was relatively new (about 1-year tenure) brought up that he had had troubling dreams about a young girl on the unit. He was mortified as he revealed the sexual overtone of the dream. As he talked, another male staff and a female staff revealed that they had also had sexualized dreams about this young girl, but had been too afraid to talk about it. None of these staff had experienced any sexual abuse as children and were in healthy age-appropriate relationships; this had been established in prior FTD sessions. All of the impacted staff, as well as other direct staff and the therapist in the group indicated that they had "felt sexual vibes" coming from the young girl, although they couldn't pinpoint the behaviors. At the next therapy with the child, the therapist noted that the girl talked about "tingly feelings" and asked her if she had those feelings about any staff. The little girl timidly acknowledged that she had and specifically mentioned each of the staff members who reported having the dreams. She then revealed for the first time the high sexual charge of her home environment and that one "uncle" had indeed had sex with her. The courageous revelation of the staff in FTD brought the team closer together and with a better understanding of the child. It ultimately helped the child access unacknowledged parts of herself and allowed the staff to intervene more directly with the girl to untangle specialness from sexuality. Because the staff no longer feared the feelings that this girl brought up in them, they no longer avoided her, and were able to sit with her as she experienced the guilt and shame over her traumatic past.

Case 2: In another team, two very seasoned and long-tenured staff, a male and female who worked on shift together were in conflict. The male complained that he had to do all of the limit setting and confrontation with children. The female staff seemed overwhelmed and backed away from aggressive boys only to have her male staff partner step in and intervene with those boys. Rather than calming the situation, however, the intercession seemed to increase the boys' aggression and derision of the female staff. In FTD the female revealed that she had been physically and emotionally abused by a stepfather who derided her and threatened her and she was frightened as she re-experienced those threats from the boys. The male staff revealed that he had stepped in as a child to protect his weak mother against an aggressive father but resented always having to be the one to save his "weak" mother. That dynamic, the weak frightened female and the strong but threatening male, actually mimicked the family of origin dynamic of some of the boys, making the milieu less safe for them and increased their need to assert their dominance through aggression rather than trusting adults. The other team members, the supervisor and the therapist all helped the female staff untangle her fear of the children as different from her childhood fear of her stepfather, and she was able, with support of her male staff partner, to step into and control, contain and deal with the aggressive boys. The male staff, in supporting the female staff's control, began to experience her as more competent and less in need of rescuing. She gained confidence, the male staff gained respect for her and no longer resented her, and the boys' aggression lessened impressively. The male and female staff worked together more collaboratively and with less interpersonal tension than prior to the disclosure and working through.

Results

In a recent organizational health survey of staff in the program, residential staff indicated that they felt encouraged and supported by their teams. Residential staff rated satisfaction with team work as 388/500; employee engagement as 403/500 and employee development as 408/500. Within the comment section for these questions, many staff indicated that FTD was a significant part of the support and development that they experienced.

The average tenure of this agency's residential staff in 2016 is 6.0 years, with 68% of staff being at Intermountain for over 2 years. This compares to a review of children's mental health service tenure in Vermont in 2007 in which only 38% of staff in children's mental health programs had a tenure of over 2 years (Pandiani & Kobel, 2007).

Colton and Roberts (2006) noted that turnover rate in the United States for child welfare agencies was estimated in 2004 to range from 30-40%. With decreased length of stays, more disturbed children, and

more paperwork, the turnover rate would be expected to increase over the past 12 years. The turnover rate at this agency in 2016 for direct care positions averaged 13% with mode being 8% and the median being 9.5%.

Some of the most meaningful impact of FTD comes from the staff and supervisors who implement it each week. Their direct comments give a flavor of what FTD has meant to them.

Marcy, a direct care staff of 6 years tenure said "There is no other job that I have worked at that does something as unique as FTD, and now that we have made it through the rough development of our team's FTD and are able to get to some real honest issues, I can't imagine working in the direct care position anywhere that doesn't have something like this. Our job of taking care of children through the good times and the rough is not easy and demands us to give a lot of ourselves every day, and FTD can be used as one tool to help take care of and give back to ourselves."

Susan, a supervisor who was seminal in the creation of the developmental/relational treatment approach and implemented it over her 35-year tenure said "I was not a big advocate of FTD and I had many reservations and concerns that have never manifested themselves. It has changed the working relationship of every partner I have supervised as they know so much more about each other. Their ability to support and confront each other has been powerful. With the level of trust developed in FTD they can confront each other more effectively and become balanced in the moment."

Mark, a direct care counselor with 10 years of experience said "Overall FTD turned me into a counselor and not a baby sitter like I once thought. FTD can be sharing one's own life story, talking about a kid in your house that has you or many people tripped up. It could be exploring past trauma or it could be just an encouraging team laugh session because of the silly things the kids do. FTD is designed to help staff create empathy for one another so that we in turn can attune and create empathy in the lives of kids so they can again be accepted by the world."

Conclusions

Direct care staff have a significant impact on the treatment of children in residential care. Particularly in a relational treatment model and with young children, who the staff are with children is arguably as important as what they do. Yet most interventions that increase self-reflection and ultimately improve the therapeutic relationship, are designed primarily for professional staff. Articles detailing the impact of self-reflective practice recommend that such interventions be regular, planned, supported by supervisors, and interactive, allowing staff to bring both personal and professional issues that impact their care into process (Cahill et al., 2004; Gatti & Watson, 2011). Family Team Dynamics is a group process used for the past 18 years at a residential treatment center for emotionally disturbed children that has made a distinct impact on direct care staff; increasing team cohesion and trust and improving the staff's ability to effectively use themselves in their relationship with the children and families they treat. The turnover rate among direct care staff is low and the tenure is high relative to other agencies working with emotionally distressed children in residential care.

The information presented is based on a case study at this program. The assumptions of correlations between FTD and increased tenure, team support and job satisfaction have yet to be demonstrated in a careful study. But, if we are to increase the humanity of our work, and to retain competent and caring staff, we must begin to try solutions that are novel, if a bit frightening. Family Team Dynamics is presented as an attempt to encourage self-reflection and increased empathy and to provide guidance, peer support and increased resonance for direct care staff in their all-important task of being someone different for the children and families we serve. If residential care is to provide the sanctuary that our children and families need to heal, we must at some level provide that sanctuary for our staff (Bloom, 2014).

References

Bleiberg, E. (2001). *Treating personality disorders in children and adolescents: A relational approach*. New York: Guilford Press.

Bloom, S. (2014). Creating, destroying and restoring sanctuary within caregiving organizations. In A. Odgers (Ed.), *From broken attachments to earned security: The role of empathy in therapeutic change* (pp. 55-90). London, UK: Karnac Books Ltd.

Cahill, J., Gilbody, S., Barkham, M., Glenville, J., Hardy, G., West, M., Cooper, C., Palmer, S., Bee, P., & Richards, P. (2004). Systematic review of staff morale in inpatient units in mental health settings. *Report for the national co-ordinating centre for NHS service delivery & organisation R & D (NCCSDO). Leeds*, NCCSDO.

Colton, M., & Roberts, S. (2006). Factors that contribute to high turnover rate among residential child care staff. *Child and Family Social Work, 12*(2), 133-142.

Davies, L., & Collings, S. (2008). Emotional knowledge for child welfare practice: Rediscovering our roots. *Smith College Studies in Social Work, 8*(1), 7-26.

Dickinson, N., & Painter, J. (2009). Predictors of undesired turnover for child welfare workers. *Child Welfare*, 88(5), 187-207.

Fahlberg, V. (1990). *Residential treatment: A tapestry of many therapies*. Indianapolis, IN: Perspectives Press.

FitzGerald, J. (2015). *Sustaining empathy* [Powerpoint slides]. Presented at seminar in Bozeman, MT.

Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self organization. *Development and Psychopathology, 9*, 679-700.

Fosha, D. (2000). *The transforming power of affect: A model of accelerated change*. New York: Basic Books.

Gatti, S., & Watson, W. (2011). Transformative professional development tool in infant mental health and reflective practice. (111811DECWatsonNeilsen.pdf) Presented at Center for Early Education and Development, 2011. Retrieved 2016, July 12.

Hoffman, K., Marvin, R., Cooper, G.., & Powell, B. (2006). Changing toddlers' and preschoolers' Attachment classifications: The circle of Security intervention. *Journal of Consulting and Clinical Psychology, 7*4(6), 1017-1026.

Hughes, D. A. (1997). *Facilitating developmental attachment*. Northvale, NJ: Jason Aronson.

Kohlstaedt, E. (2010). What is harmed by relationship can be healed by relationship. *Scottish Journal of Residential Child Care, 9*(2), 44-53.

Mahler, M., Pine, F., & Bergman, A. (1975). *The psychological birth of the human infant*. New York: Basic Books.

Main, M. & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganized attachment status. In M. T. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), *Attachment in the preschool years: Theory, research and intervention*. Chicago: University of Chicago Press.

Norcross, J. (2013). *Psychotherapy relationships that work: Evidence based responsiveness* [Powerpoint presentation]. Life Span Learning Institute Conference, 2013, March.

Olive, E. (2006). Bad Milieu, good milieu: Restoring a culture of hope. *Online Journal of the International Child and Youth Care Network (CYC-Net), 91*. Retrieved from http://www.aacrc-dc.org/public/pdfs/BAD%20MILIEU.pdf.

Pandiani, J. & Kobel, O. (2007). *Vermont mental health performance project: Mental health staff tenure and turnover FY2006*. Retrieved from http://mentalhealth.vermont.gov/sites/dmh/files/pip/DMH-PIP_March_16_2007.pdf.

Paris, M., & Hoge, M. (2010). Burnout in the mental health workforce: A review. *Journal of Behavioral Health Services and Research, 37*(4), 519-528.

Perez, L. (2011). Teaching emotional self-awareness through inquiry based education. *Early Childhood Research and Practice, 13*(2).

Schore, A. (2009, March). *Working in the right brain; A regulation model of clinical expertise for treatment of attachment trauma* [Powerpoint presentation]. Current Approaches to the Treatment of Trauma Annual Conference. UCLA, Los Angeles, CA.

Siegel, D. (2003). An interpersonal neurobiology of psychotherapy: The developing mind and the resolution of trauma. In M. Solomon, & D. Siegel (Eds.), *Healing Trauma: Attachment, Mind, Body and Brain*. New York: WW Norton & Co.

Siegel, D.., & Hartzell, M. (2003). *Parenting from the inside out: How a deeper self-understanding can help you raise a child who thrives*. New York: Tarcher/Putnam.

Spitz, R. A. (1951). The psychogenic diseases in infancy—An attempt at their etiologic classification. *Psychoanalytic Study of the Child, 6*, 255-275.

Sroufe, L. A.., & Waters, E. (1977). Attachment as an organizational construct. *Child Development, 48*, 1184-1199.

Stapleton, R., Young A., & Senstock, T. (2016). Stress in direct care staff working in residential treatment centers. *Journal of Therapeutic Schools and Programs, 8*, 71-80.

Urdang, E. (2010). Awareness of self - A critical tool. *Social Work Education, 29*(5), 523-538.

Inventing a Wheel: A Case Study of Innovations to Boost Post Residential Treatment Outcomes

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Homeward Bound

Abstract

The Merriam-Webster dictionary defines innovation as "the act or process of introducing new ideas, devices, or methods," to which I would only add the critical phrase where a need exists. With respect to therapeutic schools and programs, the most glaring need has been to identify/devise a more effective means of transitioning a client from treatment back to his or her home or other real-world setting. In this article, I share a journey of innovation that led to increased success after treatment. At the heart of each innovation was the drive to create real change that lasts. Factors that influenced the success of each collection of innovations are outlined for each respectively.

This article shares a clinical journey of innovation that began during graduate school and has continued in different yet related fields for over 20 years. It presents factors that enabled innovation to occur, as well as some of the particular clinical advances made over the course of this journey. The autobiographical "voice" of the paper was chosen to present innovation from the perspective of an innovator, with a focus on the unfolding process of innovation: this is a case study. My goal is to provide practical ideas that can be adopted and adapted to fit different programs' needs while also shedding light on some of the conditions that empower innovators, facilitate innovation, and drive progress.

Backstory

My first attempt to apply creativity and innovation to a significant problem occurred while I was a Ph.D. candidate at Virginia Tech. Though I had a Masters degree in Marriage and Family Therapy and a part time private practice, I also had a keen interest in leadership and organizational development and wondered how these fields could be synthesized. So, I endeavored to explore my interests in applying marriage and family therapy to business organizations. My dissertation committee consisted of professors with backgrounds in Organizational Development, Business Management, Statistics, Management Systems Engineering and, of course, Marriage and Family Therapy.

Ultimately, I found myself working as a contract trainer and consultant to a large health care provider consisting of several hospitals, dozens of specialty care centers, and many advanced primary care practices. The job I was hired to do was to help heal a culture of distrust, resistance, and interdepartmental conflict that had grown during the acquisition and restructuring of regional hospitals and clinics that had been purchased and then placed under a large corporate umbrella. As it turned out, the ideas I had been developing for my dissertation research proved to be perfectly suited to this need. With the help of three corporate employees in the HR department, I delivered an intensive leadership program for all executive and management levels in the organization. Due to the health care provider's readiness for change and a commitment to the process, the program was considered a success and was given credit for healing a conflict-ridden culture and for bringing about trust and collaboration within the organization. Now, twenty years later, I can see how this experience of blending principles from different fields, applying research, and thinking creatively about how to solve a problem, has repeatedly shaped the course of my career.

Some of the facilitating factors that enabled an innovative model for organizational change to be successfully developed and implemented, and that have general applicability to the behavioral health field include:

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1. Motivation to see that the intervention would bring about real, sustainable change in the workplace and at home. This led to questioning traditional approaches to leadership development both in content and process. It was determined that the short-term motivation for participants in a traditional workshop process, if never applied, would be insufficient.
2. Interest in and curiosity around searching across disciplines for inspiration and research-based practices that could be creatively applied to a problem.
3. Timing that was right for a system to invest resources in a creative and non-traditional process due to the acuity of the pain the organization was experiencing and the previous failed efforts.
4. Supportive mentors and colleagues who were willing to share their ideas and influence to help fill gaps in knowledge, resources, and credibility.
5. Passion, enthusiasm, and belief in the model as the facilitator of the process, to convince each cohort to invest their effort toward change.
6. An eventual nucleus of "flag bearing," by passionate proponents who adopted the vision of the process as their own. Principles were internalized as they began to meet on their own and hold themselves and other workshop graduates accountable.

Career Crisis

A few years after the organizational/leadership intervention experience, a career crisis within the behavioral health field was the impetus for innovation. In contrast to the experience with the health care provider, where interest and curiosity motivated innovation, the crisis described below was the catalyst for the reorientation of my career mission and for the innovations that followed.

I was working as a therapist in a wilderness program when a new student presented with bright green hair, depression, school refusal, conflict at home, and a growing pattern of substance abuse. Like many of our students, he was initially resistant to therapy. However, he soon made a turn and did extremely well in our wilderness program. I was thrilled with his engagement and substantial progress. Near the end of our program, his educational consultant and I advised that he proceed to a therapeutic boarding school as the next step, and by all accounts he seemed to thrive there as well.

Over the 15 months of his treatment, I grew close to his parents. Occasionally, when they came into town to visit him, we went to dinner. In my mind, this young man was one of our program's great success stories in the making. Then he went home.

Within a month, away from the structure of residential treatment, he fell back into old habits, his depression resurfaced, and he returned to the destructive friendships he had had prior to treatment. In tears, his mother said, "We have done everything we were asked to do. It's not working. Now what?"

It was true. They had followed the professional recommendations precisely. They were engaging in family therapy, individual therapy for their son, and having him attend substance abuse group therapy. All of these efforts were falling short.

In an attempt to help the family, I flew to the family's home to visit their son. I believed that the relationship forged between us in the wilderness would endow me with the influence needed at this critical time of transition. Instead, he locked his bedroom door and refused to come out. I spent the day with his parents, at a loss as to how to guide them.

The family's crisis had now become my own and I realized there was a conspicuous need for a better solution for transitioning from treatment. On the plane ride back that night, I decided to take action. I felt it was both my duty and a unique career opportunity to bridge this gap.

Driving Mission and Vision

In the early 2000's, within the private pay niche of adolescent treatment, little attention was being paid to the factors research suggested were most significant in maintaining gains after discharge, namely: family involvement during treatment, the stability of the environment the adolescent returns to, and aftercare for the teen and his or her family (Burns, Hoagwood, & Mrazek, 1999; Frensch & Cameron, 2002).

Conventional aftercare protocol involved a discharge plan that generally recommended individual therapy for the teen or young adult, a 12-step self-help group for those with addiction issues, family therapy, and medication management under the care of a psychiatrist. An obvious omission, however, was a lack of case management by someone dedicated to aftercare who understood the importance of continuity of care between professionals. Someone other than a parent needed to oversee this, but it rarely happened.

Another weakness was the absence of a coherent aftercare model based on best practices that focused not only on the teen, but on reshaping and strengthening the family in key ways. Given that treatment programs are typically hundreds if not thousands of miles away from where the client resides, it was believed that professionals local to the family would be better suited to fill this role so treatment programs did not see it as their job. Yet, too often, no one was "owning" the outcome and providing the required level of collaboration and support needed.

Conscientious treatment programs had always strived for long-term success, but few extended their services past discharge. Similar to the decision I made as a graduate student to develop a model to bring about organizational change, I decided to design a better way to manage this transitional gap through intensive processes that would be applied and practiced in the client's real world settings.

Three Innovations of Our Continuing Care Model

At the founding of our transition services program in the early 2000s we had a compelling vision, a small and passionate team, clinical research that provided a starting point for our philosophy, and a blank slate. With these resources at our disposal, we faced the significant challenge of creating an effective transition process that would work no matter where the client resided. Our model had to work from a distance. This fact lies at the heart of most of the innovations we have implemented over the last decade. As a side note and word of caution to innovators: an even larger hurdle existed that I was unaware of that easily could have been the undoing of our fledgling organization—timing. It would take several years before the practice of intensive continuing care and case coordination would be generally adopted as best practice within our field.

Below are three tenets or philosophies to which we subscribed in our model. We built our model on the tenets because we believed they offered promise to increase long-term success.

Parents as Game Changers

In our work with teens and young adults after treatment, the research highlighting the central role parents play in long-term success was verified. When taking into account the key factors identified by a meta-analysis of the then existing research on long-term success after treatment (Hair, 2005), it became clear that outside the student themselves, parents have the potential to have the greatest influence on the eventual outcome.

To address this, we interviewed dozens of parents who had children in treatment. Most parents reported feeling depressed and angry, exhausted, hopeless, and out of ideas when they placed their teen in treatment. They were often at odds with their co-parent and their personal mental health was at an all-time low. Though parents generally had improved their mental health status during the treatment program, they reported that they still were not sure about their role during and after treatment and had significant anxieties about the upcoming transition. They also reported that they tended to lack a concrete plan, key skills for their resumed but modified parenting role, realistic expectations, and efficacious coaching and case coordination to help them play their role through the phases of transition. This interview data served to identify our job. We would provide that missing piece by first elevating the focus of the parent's role during and after treatment and then intensively supporting them in that role through education, timely support, practical advice, and assisted practice over time.

In-Home

Given the evidence base that existed as to the efficacy of in-home treatments such as Multi Systemic Therapy (MST; Henggeler, 2012), we believed the best setting in which to assess and intervene during

the transition would be with the family in their home(s), and/or with the young adult where he/she would be living.

Based on that literature, as well as our parent interviews, we set the following goals for an in-home or on-site visit, which we viewed as an essential aspect of the transition work.

1. Gain a nuanced level of understanding of the family's culture, dynamics, strengths and weaknesses;
2. Customize the family transition plan after having experienced the family in action;
3. Unify members of the family around their vision and plan;
4. Infuse the family system with confidence through practical knowledge, key skills, and clarity on their roles and the path forward;
5. Strengthen the support network (friends, family, and professionals) through education, coordination, inspiration, and encouragement

We also decided to complete a full assessment of the graduate and their family after spent time at their residence, in order to address gaps in the teen's or young adult's discharge plans and help parents navigate conflicts and challenges within their co-parenting or around specific issues such as schooling, employment, and boundaries..

Informed by both research and the clinical feedback of parents, we believed that the key was to ensure that everyone had a clear plan for moving forward, skills required to do their part, and the support needed. Our goal was to facilitate and coordinate the execution of the transition plan during the first few months after discharge.

Natural Mentors

The next significant decision was to adopt a philosophy of a community-based support team. Many evidence-based mental health programs are founded on the premise that a positive, multi-faceted support system is critical in promoting and maintaining positive treatment outcomes (e.g., Assertive Community Treatment, Wrap Around, etc). One program, MST, has the strongest parallel to transition care in the private mental healthcare system. MST is typically delivered in the public mental health system. It involves working with the youth and family in their natural environments (e.g., home, school, community) with the goal of creating and maintaining seamless support. MST intervenes at the family level, empowering families with skills and resources to effectively communicate with, monitor, and support their child and create a community of social support amongst the family, adult role models, peers with pro-social leanings, and community leaders (Henggeler, 2012).

The research support for MST suggests that youth who receive this multi-level, multi-system support have reduced rates of suicidality, improved family functioning, improved school attendance, and reduced rates of externalizing behavior (Henggeler, et al., 1999; Huey et al., 2004; Rowland, et al., 2005; Schoenwald, Ward, Henggeler, & Rowland, 2000). MST offers a model that we believed generalized to the new level of care we sought to add to the private mental healthcare system. Based on such research, we decided to use a "Home Team" approach. The Home Team concept involved fostering a network of support that extended beyond mental health professionals. The program encouraged parents and the son or daughter in treatment to identify individuals who were a positive influence, who cared about their family, and who were naturally in their lives. This group was comprised of immediate and extended family, neighbors, friends, members of the clergy, coaches, etc. In addition, a Home Team included paid professionals such as therapists, nutritionists, physicians, and, if they chose, the treatment program therapist. Parents and students were encouraged to share appropriate levels of information about their time in treatment as well as their goals for the future so that Home Team members could play a supportive role within their sphere of influence. Based on the research, we believed that these natural systems of support were critical because they appeared to extend further and last years beyond professional support (DuBois & Silverthorne, 2005). During the course of service, it was common for the Home Team to meet in the client's home to celebrate the growth that occurred and remove shame or stigma around having undergone treatment. Given the extensive research on the association between shame and mental health treatment (Hinshaw, 2009) we believed this to be an important aspect of the program. Furthermore, it provided an occasion for affirming the client's decision and acknowledging his or her progress.

The overarching goal during the creation of this model was to employ any principle that had power to significantly reduce recidivism and increase long-term success. Sometimes features initially included in our model, though powerful, were not easily adopted, and had to be modified or dropped altogether, i.e. video coaching (Thayne, 2013).

Over time, the Home Team concept remained in the model, in spite of the fact that some parents had initially been distanced or cut off from their natural support system as their child's problems or poor behavior mounted. Through proper education and increased communication, however, these bridges were reestablished and strengthened.

Upon reflection, a number of factors facilitated the process of implementing a transition model. The facilitating factors included the following:

1. Most innovations do not flourish if the timing is not right. In this case, a focus on aftercare was not timed right. We believed that the field was not experiencing enough pain related to client relapse and parents were not necessarily asking for this kind of support either. Over time, that changed, but the initial years were particularly challenging. The facilitating factor was perseverance.
2. Confidence was necessary. Belief in our approach was founded on knowing that it was based on true principles, a real need, and upon having a team of people who were dedicated to finding the answers.
3. Emotional and financial resources were needed to endure a significant period of time before there was greater adoption within the field.
4. As a small organization, we were able to pivot when something was not working or when we had planned wrong. We could start and stop and innovate, without red-tape restricting us to "the way it is done." However, in hindsight, we held onto certain methods far longer than we should have. A better approach would have been to listen to clients and constituents more quickly and make pivots early. We learned from this process that flexibility was a facilitating factor.

Technology and Licensing Model Innovation

In keeping with the requirement to be effective from a distance, the development of technology was a natural next step. Close on the heels of Facebook, we created a web based parent portal designed to facilitate greater family involvement in treatment, as well as social networking to build an informed and engaged Home Team. Our challenge was to find more ways to leverage and extend the support of the Home Team during and after treatment.

This use of technology to facilitate parental involvement and "Home Team-building", which research has shown to be essential to long-term success (Gorske, Srebalus, and Walls, 2003; Stage, 1999; Sunseri, 2001), constituted an additional innovation. The portal provided parent access to a library of materials to support them in gaining the knowledge and skills necessary to play a key role in their teen's recovery. It also allowed individual treatment programs to customize the curriculum and educate families according to particular diagnoses and challenges, while automating the scheduled delivery of curriculum. Programs that seek to provide transition care may want to consider a similar multi-faceted tool to facilitate transitions.

This model led to exploring ways to use "best practices" research through technology. We believed the Home Team concept was powerful, but that its reach needed to be extended so as to involve the Home Team in the treatment process as early as possible. Rather than wait until the final week or two of treatment or until after the client returns home, the portal allowed Home Team members to access information about the client's progress, facilitated communication, and enabled them to track, maintain and build their relationship.

Parents (or young adults over 18 years old) determined who would be on the Home Team and what information they could access via the platform. This boosted timely case coordination among professionals. One of the obvious benefits of time away in residential treatment is that young people can be separated from the negative influence of peers while therapeutic work is taking place. Unfortunately, treatment also indiscriminately separates them from positive influences. The portal

provided a means of maintaining and even deepening positive connections throughout treatment and beyond.

Upon reflection, we realized a number of factors facilitated this technology innovation.

1. A commitment to creating a program that was successful anywhere a client lived. We were pushed to find a way to increase success by coordinating cases, involving parents earlier in treatment, including natural mentors, and encouraging parent growth. We learned that challenges facilitate creativity and innovation.
2. A creative identity focused on a mission to increase the success of treatment allowed us to see ourselves as more than a provider of transitional services, opening the way for us to move into technology. We learned that a flexible, responsive professional identity facilitates change.
3. Advances in technology that make the second generation of the portal more user friendly and mobile. We learned to work towards continual development, which is especially salient in an online platform.

Licensing Model

A culture of innovation is commonly believed to be the most important source of growth, productivity and strength within an organization (Edquist, 2005) and is key to its longevity. Progressing within a changing landscape through innovation applies not only to clinical methods, but to the entire business model, including how clients find out about and gain access to products and services.

Good programs have their therapeutic plates full, maintaining focus on the day-to-day demands of intensive treatment for the young person, but are increasingly recognizing the need for transitional care. Given that continuing care processes are so divergent from those within a treatment facility and have previously been seen as outside the program's role, we came to believe that filling the gap could be done well by an outside entity that could focus its creativity, resources, and mission to innovate systems, technology, curriculum and processes. Therefore, we began to develop our consultative competencies and licensed a model to dovetail our systems with residential treatment models.

Through that process we have come to appreciate factors that facilitate business model innovations.

1. Timing and patience are essential in the process of organizational change. Innovation requires stepping out first, and then patiently but actively weathering the storm while the culture shifts.
2. Building credibility and respect within the infrastructure is key to weathering the storm during times of change.
3. Collaboration with stakeholders facilitates organization change. We found that continued communication and interaction with programs kept us responsive to the needs and shifts in the business climate.
4. Innovations sometimes require making changes in the way we partner. To innovate, we found ourselves pursuing depths and avenues for partnering with programs, which ultimately led us to the decision to seek licensing. We found it was beneficial to be open to new ways of partnering and applying our model.

Conclusion

Thirteen years ago my professional crisis spawned an innovation in continuing care after treatment. Looking back now at what has been accomplished I have come to believe that we will be successful more often than not, when our innovations address a painful need in better ways, are timed right, and are implemented strategically so that they anticipate future needs.

References

Burns, B. J., Hoagwood, K., & Mrazek, P. J. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Child and Family Psychology Review, 2*(4), 199-254.

Christensen, C., Hall, T., Dillon, K., & Duncan D. (2016) Competing Against Luck: The Story of Innovation and Customer Choice. New York, Harper Collins.

DuBois, D. L., & Silverthorn, N. (2005). Characteristics of natural mentoring relationships and adolescent adjustment: Evidence from a national study. *Journal of Primary Prevention, 26*(2), 69-92.

Edquist, C., (2005) *Systems of Innovations: Technologies, Institutions, and Organizations.* Routledge, London & New York, Taylor and Francis Group.

Frensch, K. M., & Cameron, G. (2002). Treatment of choice or a last resort? A review of residential mental health placements for children and youth. *Child and Youth Care Forum, 31*(5), 307–339.

Gorske, T. T., Srebalus, D. J., & Walls, R. T. (2003). Adolescents in residential centers: Characteristics and treatment outcome. *Children and Youth Services Review, 25*(4), 317–326.

Hair, H. J. (2005). Outcomes for Children and Adolescents After Residential Treatment: A Review of Research from 1993 to 2003. Journal of Child and Family Studies, 14 (4), 551-575.

Henggeler, S. W., (2012) Multisystemic Therapy: Clinical Foundations and Research Outcomes. *Psychosocial Intervention, 21*(2) 181-193.

Henggeler, S. W., Rowland, M. D., Randall, J., Ward, D. M., Pickrel, S. G., Cunningham, P. B., et al. (1999). Home-based multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis: Clinical outcomes. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(11), 1331-1339.

Hinshaw, S.P. (2009). *The mark of shame: Stigma of mental illness and an agenda for change.* Oxford: Oxford University Press.

Huey, S. J., Henggeler, S. W., Rowland, M. D., Halliday-Boykins, C. A., Cunningham, P. B., Pickrel, S. G., & Edwards, J. (2004). Multisystemic therapy effects on attempted suicide by youths presenting psychiatric emergencies. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(2), 183-190.

Rowland, M. D., Halliday-Boykins, C. A., Henggeler, S. W., Cunningham, P. B., Lee, T. G., Kruesi, M. J., & Shapiro, S. B. (2005). A randomized trial of multisystemic therapy with Hawaii's Felix class youth. *Journal of Emotional and Behavioral Disorders, 13*(1), 13-23.

Schoenwald, S. K., Ward, D. M., Henggeler, S. W., & Rowland, M. D. (2000). Multisystemic therapy versus hospitalization for crisis stabilization of youth: Placement outcomes 4 months postreferral. *Mental Health Services Research, 2*(1), 3-12.

Stage, S. A. (1999). Predicting adolescents' discharge status following residential treatment. *Residential Treatment for Children and Youth, 16*(3), 37–56.

Sunseri, P. A. (2001). The prediction of unplanned discharge from residential treatment. *Child and Youth Care Forum, 30*(5), 283–303.

Thayne, T. R., (2013). *Not by Chance: How Parents Boost Their Teen's Success In and After Treatment.* Charleston, Advantage Media.

Autonomous Programming: The Benefits and Challenges of Emerging Mentorship Models

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Abstract

Therapeutic "after-care" programs have specific profiles to address the various behavioral and clinical needs of their clients. Among many services, these standard models typically offer daily structure, group therapy, individual therapy, and life-skill phases with increasing responsibility over time. Conversely, autonomous programs often implement an underlying substructure, little-to-no phase work, optional group therapy, and in some cases, private individual therapy, all of which position clients to experience first-stage autonomy—a factor that seems important for launch into confident adulthood. Herein we discuss important components of autonomous programming, and the benefits and challenges of these emerging mentorship models.

Keywords: young adult, transition, after-care, autonomy, independent living, mentorship, failure to launch

Generation Y is the largest and most behaviorally varied generation in American history (e.g., Elmore, 2010). Generation iY, influenced by the "i" world, are the younger Millennials born after 1990. Their world has been mediated by technology and shaped by the internet—iPod, iBook, iPhone, iChat, iMovie, iPad, and iTunes—and for a majority, life is about "i." These young adults don't process or learn like previous generations. These young men and women have spent countless hours giving their opinions via blogs, Facebook, Twitter, etc., and thus largely define their sense of self-worth by what they "uploaded" and not by what they "downloaded" (Elmore, 2010; Kins & Beyers, 2010).

These young adults have a diminished sense of confidence or accomplishment. This could be due to lack of their own experiences in overcoming challenges, facing difficult social encounters, dealing with anxiety of sharing a passion, or revealing some vulnerability to the world. It is of little surprise that there is considerable anxiety around embracing adulthood. Failure to launch (FTL) is an increasing trend in the United States, and the collective therapeutic industry is just beginning to problem solve the FTL issue among young adults. Fortunately, the spectrum of support is increasingly broad, and measured outcome trends are starting to influence programmatic design. Post-primary treatment programs for young adults, often referred to as "after-care" exist on a broad support spectrum (from dependence to independence) designed to address a range of clinical and behavioral issues. In very general terms, the "heavy" or dependent end of the spectrum is often appropriate for clients who struggle with managing basic tasks, who may have executive functioning issues, anger management issues, learning disabilities, etc., and who benefit from increased supervision combined with a rigid, structured routine. Whereas, the "light" end of the spectrum is often appropriate for clients who struggle with less severe clinical issues, and who are in a better place emotionally to progress with less supervision. These clients have demonstrated some measure of determination to function with greater responsibility and autonomy. Clients arrive at these programs through various channels, most are struggling with FTL syndrome, and the majority of clients are engaged in some form of clinical therapy.

The therapeutic after-care industry is predominantly a therapeutic continuing-care industry. Clients who reach the end of their therapeutic program are often poorly equipped to transition into society as

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self-reliant, productive, young adults, regardless of where their previous program fell on the spectrum. The issue does not stem from inadequate support or programming, as these programs are saturated with quality people who consistently do valuable work. So, what's amiss? Perhaps a contributing factor to marginal, post-program performance is that clients most often terminate their programming with prevalent, after-care programs, as opposed to lesser-known and relatively scarce autonomous programs provide that crucial, "edge" experience where clients live much as they would post treatment. Autonomy represents an inner endorsement of one's actions, the sense that one's actions emanate from oneself and are one's own (Deci & Ryan, 1987). Self-direction is at the core of autonomous programming, thus autonomous programming can be defined as a mentor based strategy that is driven by client directed components (i.e., volunteerism, internship, classes, etc.) though initially supported by a pre-determined sub-structure of routine. These activities are eventually, completely replaced or augmented by additional and/or more robust client-directed components. It is worthy of mention that "right fit" is critical in considering any programmatic placement, and evaluation of client commitment beyond the normal rigors of "standard" programming is important when looking at continuing treatment in any autonomous program.

We have known for decades that the process of realizing autonomy, while maintaining a healthy relationship with parents and family, is a critical stage-salient task of adolescence (Collins, 1990; Cooper & Carlson, 1988; Grotevant & Cooper, 1985; Hill & Holmbeck, 1986; Moore, 1987; Steinberg, 1990). Self-reports from adolescents regarding autonomy in the home environment, vis-à-vis parents, have been linked to numerous healthy outcomes: better adjustment to later separation, greater assertion, increased resistance to peer-pressure, improved self-esteem, and decreased rates of reported loneliness after leaving home to attend college (Kenny, 1987; Moore, 1987; Ryan & Lynch, 1989). When social conditions support this psychological need for autonomy among young adults, these individual develop inner resources that allow them to cope better with adversity and flourish in their adult development (Ryan, Deci, & Vansteenkiste, 2015). Indeed, much of the challenging behavior we see from young adults in programming can be traced to efforts a thwarting the will of authority. For not only do young adults crave something very different than control from others, they like everyone else, desire to feel in control (Evans, 2015).

Why then are autonomous programs not more prevalent? Autonomous programs are more difficult to manage as there exists no rigid structure or hard set of rules that clients must follow. This strategy introduces a whole suite of variables that start-up programs are often unwilling to endure. Additionally, many of the clients exiting primary-care are not yet prepared for program autonomy, thus typically structured programs remain the greater initial necessity. While this may present as contrary to the argument for autonomous strategy, it factually points to a critical gap in programming. This gap exists between completion of typical primary- care programs and legitimate client self-sufficiency and independence. Readiness for a more autonomous programmatic structure is not solely about clinical diagnosis, rather, understanding how and to what degree symptom presentation affects a client's ability to manage their daily routine, and academic and professional goals. Prior to arrival, clients may benefit from submitting a commitment/interest letter to the program that specifically addresses the need for focus and attention to the process.

Primary Components of Autonomous Programming

There exists a suite of components that set autonomous programs apart from traditional, after-care programs. This is not to say that components of traditional programs do not offer overlap, rather, all of these working together seem prime. Autonomous models require a high mentor-to-client ratio, and program models that stray from the strategy of regular, one-on-one engagement will find their results less effective.

Residential and Non-Residential Phases

Many clients require a residential setting as they transition from primary or after-care programs. Residential stages are suitable for clients who need to hone their basic life skills as they grow in their autonomy. Non-residential stages are better suited for clients who have demonstrated a sense of organization and intention sufficient to warrant independent living. Most clients in residence should follow with non-residential programming to remain in the therapeutic/mentoring loop, and to maintain productive momentum as they transition to living fully on their own.

AUTONOMOUS PROGRAMMING

Urban Environment

Cities are the knowledge and technology-based centers that offer the best realm for young adults to engage in progressive activities that will challenge them to become responsible and self-sufficient. The following components of an urban environment present opportunities that can help shape and prepare a young adult for myriad adult life demands. Urban environments can be intimidating, and clients need to be quickly oriented to their surroundings to help prevent anxiety in a novel setting.

Academic proximity. Larger cities offer multiple academic institutions ranging from community colleges that offer an inexpensive alternative for clients to pursue general education credits to state and private universities. These institutions offer bachelor's degrees through Ph.D. level graduate and medical programs.

Careers and jobs. Big metropolitan areas offer the greatest diversity of entry-level jobs—those most often sought by clients in transition. They also offer a vast array of jobs at all tier levels and career opportunities that keep pace with the evolving economy and workforce.

Concentrated activity space. Activity space is the radius within which people conduct their daily activities: going to work, going to school, accessing resources, participating in community activities and so forth (Hagerstraand, 1970). Concentrated activity space allows clients to more easily and efficiently structure time, and manage events on their schedule.

Cognitive mapping challenges. The heterogeneous nature of the urban environment demands that young adults utilize cognitive mapping, a skill set that is often weak among transitional young adults. Cognitive mapping is a process comprising psychological transformation by which an individual acquires, stores, codes, recalls, and decodes information about the locations and characteristics of phenomena in his/her spatial environment. Cognitive mapping is important for human adaptation and is required for everyday environmental navigation and behavior (Downs & Stea, 1973).

Entertainment and recreation. Urban areas clearly offer entertainment and recreation options unavailable in rural or suburban locations. While industry professionals know that the vast entertainment/recreation options can provide fertile ground for relapse, the benefits of these options should be well understood, as young adults need experiential opportunities in situations that do not guarantee best choice scenarios or outcomes. With proper mentoring, the young adult's experience of autonomy and trust often mitigates many negative behaviors.

Social diversity. A distinct advantage of urban environments is social diversity. Many clients exiting therapeutic programs have had minimal exposure to individuals outside of their socioeconomic class. Interacting with people from various walks of life helps establish intrinsic values, which are necessary for developing empathy—a trait critical for peer understanding and emotional connection. Gurin, Dey, Hrtado, and Gurin (2002) posit and test a theory of how experiences with diversity influence student educational outcomes. Based on psychological concepts that trace back to Piaget (1971, 1985) and Erikson (1946, 1956), these researchers explain that experiences with diversity, particularly interaction with diverse peers, and curricular exposure to diversity, provide the challenge that is necessary for the development of a healthy sense of self and more complex cognitive structures.

Transportation ease. Ease of transportation is a major factor when empowering young adults to strike out on their own for jobs, school, community service, internship, etc. Numerous cities have public transportation systems that allow freedom of movement at low cost.

Affordable housing. Cities have a greater availability of affordable and small dwellings than do suburbs and rural areas (Dielmann & Mudler, 2002). Low-cost housing is beneficial as young adult's transition from residential phases of programming to more independent stages of programming that include living in one's own home.

Trait Assessments

There are various, recognized, character assessments (i.e. Myers-Briggs Type Indicator, Strong Interest Inventory, The Work Engagement Profile) that can be administered to help better understand the

global functioning of young adults as related to passions, career and academic prospects, and suitability for transition to independent living. These evaluations, conducted immediately following matriculation process, can offer information helpful for mapping basic life plans, and setting realistic goals that match client's core interests. Blume (1992) suggests that college students can improve their study habits by knowing their Myers-Briggs Type Indicator results and how different learning styles are associated with each preference. Students who completed the Strong Interest Inventory and participated in a social cognitive-based group feedback and interpretation session exhibited higher levels of post-test career decision-making self-efficacy and differential career beliefs about students in the other experimental groups (Luzzo & Day, 1999). Young adults transitioning towards independence need to work, and intrinsic rewards at work are necessary for them to stay motivated. Research suggests that younger adults have lower levels of work engagement than older adults (James, McKenchie, & Swanberg, 2011; Schaufeli & Bakker, 2003; Schaufeli, Bakker, & Salanova, 2006; Simpson, 2009). Thus it is important to garner some standard measure of reward and engagement. The Work Engagement Profile measures the extent to which the four types of intrinsic rewards (meaningfulness, competence, choice, and progress) are experienced within a respondent's work (Jacobs, Renard, & Sneglar, 2014), and this information is useful (in conjunction with the other assessments) for clients making career choices.

Possibly the best predictor of academic and career success is grit. Grit is a compound personality trait (Hough & Ones, 2002) broadly defined as the tendency to pursue long-term goals with sustained zeal and hard work. Grit has been shown to predict achievement in academic, vocational, and avocational domains (Duckworth, Peterson, Matthews, & Kelly, 2007; Duckworth & Quinn, 2009; Duckworth, Quinn, & Seligman, 2009; Von Culin, Tsukayama, & Duckworth, 2014). Grit is typically assessed using self-report or informant-report questionnaires. Duckworth and Winkler (2013) explains that grit scales comprise items describing consistency of interests and long-term persistence of effort. Young adults in therapeutic programs often score low on the Grit Scale (and work engagement assessments that measure confidence). Instilling this trait is a challenge that begins with routine self-care, community involvement, internships, and employment. Each of these endeavors require consistency and follow-through.

Volunteerism

Community service tasks are important to begin the process of consistent, productive activity to foster the grit effect. Young adults in programming often experience a sense of entitlement and struggle to embrace the notion that volunteerism is an end in and of itself. Giving of their time serves the community and instills a sliver of altruism that erodes that sense of entitlement.

Mentorship Immersion

Mentorship immersion refers to the strategy of coupling clients with multiple mentors who are chosen specifically for their ability to give advice on particular areas of interest or need. Many professionals identify a mentoring relationship as an essential step in achieving success in business and academia (Roche, 1979). Indeed, most successful people can point to a mentor who was crucial to their career growth and success (Ramani, Gruppen, & Kachur, 2006). Program success on the mentorship front requires a substantial number of community connections to meet the mentoring needs of clients who have a broad range of interests and budding skill sets. Mentors need to fully support their clients while providing significant challenge. Daloz (1986) states that effective mentor-protégé relationships should balance three elements: support, challenge, and a vision of the protégés future. If mentors are overly supportive without challenging clients, the clients do not grow professionally; on the other hand, challenging without supporting causes clients to regress in their development. Effective mentors balance support with challenge by providing opportunities and setting positive expectations (Bower, Diehr, Morzinski, & Simpson, 1998). Though short-term mentoring interventions may succeed in cultivating feelings of closeness and hence promote positive outcomes, they may also arouse a sense of dependency that cannot be satisfied. In particular, unrealistic expectations for the continuation and deepening of the relationship may arise (Goldner & Mayseless, 2009). Such expectations are not fulfilled by short-term organized mentoring that is limited in time and investment (McAuley, 2003; Spencer, 2007). This dependency, however, can be dissipated by strong community involvement and healthy peer attachment.

AUTONOMOUS PROGRAMMING

Private Therapy

Most young adult clients exiting primary or after-care programs have been immersed in an environment where group therapy and semi-private therapy (where personal issues may be relayed to staff and/or parents) are typical. While research (Philips, Wenneberg, Werbart, & Schubert, 2006) comparing the results from individual therapy and group therapy demonstrate no significant differences in outcomes in the two forms of treatment, autonomous programs recognize the need for clients to move beyond the shared model of therapy, and into a private format where sessions are wholly in confidence (with the exception of legitimate "red-flag" issues covered by release), and program staff are generally relieved of the role of "gatekeeper" to information flow.

Parent Scarcity

Parent enmeshment is a persistent and widespread problem that hinders the progress of reversing the FTL phenomenon. It involves the application of developmentally inappropriate levels of parental direction, financial assistance, problem-solving and monitoring. This involvement often contributes to undesirable traits such as narcissism, entitlement, poor coping styles, anxiety, stress, and lack of grit. This unhealthy attachment is associated with lower quality parent-young adult communication and has an indirect effect on lower family satisfaction (Segrin, Woszidlo, Givertz, Bauer, & Murphy, 2012; Segrin, Woszidlo, Givertz, & Montgomery, 2013). During the first few months of autonomous programming, parents can best be served through parent coaching, where staff can walk them through the program/client process so that they have realistic expectations, and are not attached to unreasonable notions of time scaled outcomes.

Upon completion of primary-care programs, young adults regularly experience a heightened sense of accomplishment and carry that momentum to the next stage/program. Despite the "pink cloud" effect, these young adults often experience momentum drag, or stall when faced with the reality of adulthood. About two weeks post-primary treatment clients often experience a downturn in attitude, followed by an upswing, highlighted by the following time-linked behaviors: 1st month) rapid apathy, recurrent patterns, weak commitment, needy; 2nd month) increasing wants, deflection, blame shifting, self-doubt; 3rd month) growing acceptance, greater rapport, openness, willingness to learn, tired of status quo. This initial stall frequently coincides with the parent's need to: 1) comfort and/or rescue their adult child; and 2) re-hash the program's credentials, integrity, strategy, etc. Consequently, parent involvement in the first three months is highly disruptive and only serves to exacerbate this stall effect.

Considerations and Challenges

Clients new to autonomous programming often struggle initially to manage their time, even with an introductory sub-structure in place (i.e., waking times, chore schedule, therapy, community service, etc.). It is paramount to establish a routine from the beginning so that discipline carries over to when clients set their own agenda and schedule. Autonomy offers the opportunity for placing one's self in any number of compromising situations. Substance use is one example that is often broached by parents and clinicians. Notwithstanding the legal ramifications, such behavior is likely best responded to from a clinical perspective rather than one viewed as authoritarian or punitive. Unsupervised overnight stays with friends or sexual partners are to be expected, and it is important for obvious reasons that clients are accountable (by ways of communication with staff) for their location, and time of return to the residence.

Conclusion

While considering the aforementioned components of autonomous programming, it is worth emphasizing the importance of how structure is presented and implemented over time. A predetermined schedule mandated to every program participant, whether initial or ongoing, can reinforce the idea that young adults cannot make decisions for themselves. Whether actual or perceived, loss of control can and often does lead to lack of accountability for, or acceptance of, the necessary steps to keep moving forward. An effective strategy includes a short window of rigid, programmatic sub-structure, co-produced by clients and staff, followed by an overlay of activities that represents the schedule of their choosing based on interests, internships, work, school, etc. Response to this self-actualized autonomy is an increased level of openness to, and greater ongoing engagement

in the overall process of acquiring skill sets necessary for successful transition into independence. Additional programmatic traits driving this increased level of engagement and buy-in are private therapy, parent scarcity, limited social restrictions, and an ongoing collaborative discussion about goals and how they affect overall length of stay in the program. The benefits of autonomous programming are only just beginning to be explored and the literature is rife with examples that support the developmental benefits of autonomy (Deci & Ryan, 1987; Ryan et al., 2015). Programs can initially offer clients a sense of autonomy, rather, mentors can provide clients with high quality interpersonal relationship and out of that relationship context, clients can experience and begin to exercise their own sense of autonomy (Reeve & Jang, 2006).

It is well known that young adults encounter difficult obstacles on the path to self-sufficiency, and young adults in therapeutic programming generally struggle with these obstacles more than most. We suggest that these are necessary challenges that foster the "grit effect" and if met within an autonomous programmatic environment, the final transition out of programming and into self-sustained adult life is more readily achieved.

References

Blume, S. (1992). Learning styles. In: J. N. Gardner & A. J. Jewler (Eds.), *Your college experience: Strategies for success* (pp. 49-64). Belmont, CA: Wadsworth.

Bower, D. J., Diehr, S., Morzinski, J. A., & Simpson, D. E. (1998). Support–challenge–vision: a model for faculty mentoring. *Medical Teacher, 20*(6), 595–597.

Collins, W. A. (1990). Parent-child relationships in the transition to adolescence: Continuity and change in interaction, affect and cognition. In: R. Montemayor, G. R. Adams, & T. P. Gulotta (Eds.), *From childhood to adolescence: A transitional period? Advances in adolescent development* (pp. 85-106). Newbury Park, CA: Sage.

Cooper, C. R., & Carlson, C. (1988). Individuality and connectedness in family relationships during early adolescence: Gender differences and predictors of self-esteem. *In meetings of the Society for Research in Adolescence, Alexandria, VA.*

Daloz, L. A. (1986). Effective Teaching and Mentorship: Realizing the Transformational Power of Adult Learning Experiences. *San Francisco, Josey-Bass.*

Deci, E. L., & Ryan, R. M. (1987). The support of autonomy and the control of behavior. *Journal of Personality and Social Psychology, 53*, 1024 –1037.

Dieleman, F. M., & Mulder, C. H. (2002). The geography of residential choice. In: J. I. Aragonés, G. Francescato & T. Gärling (Eds.), *Residential environments: Choice, satisfaction, and behavior* (pp. 35–54). Westport, CT: Bergin and Garvey.

Downs, R. M., & Stea, D. (1973). *Image and environment: Cognitive mapping and spatial behavior.* Chicago, IL: Aldine.

Duckworth, A. L., Peterson, C., Matthews, M. D., & Kelly, D. R. (2007). Grit: Perseverance and passion for long-term goals. *Journal of Personality and Social Psychology, 92*, 1087–1101. doi:10.1037/0022-3514.92.6.1087.

Duckworth, A. L., & Quinn, P. D. (2009). Development and validation of the Short Grit Scale (Grit-S). *Journal of Personality Assessment, 91*, 166–174. doi:10.1080/00223890802634290.

Duckworth, A. L., Quinn, P. D., & Seligman, M. E. P. (2009). Positive predictors of teacher effectiveness. *The Journal of Positive Psychology, 4*(6), 540-547. doi:10.1080/17439760903157232.

Duckworth, A. L., & Winkler, L. (2013). *True grit. The observer, 26*(4), 1-3.

Elmore, T. (2010). *Generation iY: Our last chance to save their future.* Poet Gardener Publishing.

Erikson, E. (1946). Ego development and historical change. *Psychoanalytic Study of the Child, 2,* 359–396.

Erikson, E. (1956). The problem of ego identity. *Journal of the American Psychoanalytic Association, 4,* 56–121.

Evans, I. (2015). Autonomy, limits and experiencing success.

Goldner, L., & Mayseless, O. (2009). The quality of mentoring relationships and mentoring success. *Journal of Youth and Adolescence, 38*, 1339–1350. doi:10.1007/s10964-008-9345-0

Grotevant, H. D., & Cooper, C. R. (1985). Patterns of interaction in family relationships and the development of identity exploration in adolescence. *Child Development, 56,* 415-428.

Gurin, P., Dey, E. L., Hurtado, S., & Gurin, G. (2002). Diversity and higher education: Theory and impact on educational outcomes. *Harvard Educational Review, 72*(3), 330–365.

Hägerstraand, T. (1970). What about people in regional science?. *Papers in regional science, 24*(1), 7–24.

Hill, J. P., & Holmbeck, G. N. (1986). Attachment and autonomy during adolescence. *Annals of Child Development, 3*, 145-189.

Hough, M. L., & Ones, D. S. (2002). The structure, measure, validity and use of variables in industrial, work and organizational psychology. In: N. Anderson, D.S. Ones, H.K. Sinagil, & C. Viswesvaran (Eds.), *Handbook of industrial, work and organizational psychology: Volume 1: Personnel psychology*. Sage.

Jacobs, S., Renard, M., & Snelgar, R. (2014). Intrinsic rewards and work engagement in the South African retail industry. *SA Journal of Industrial Psychology, 40*(2), 13-pages. http://dx.doi.org/10.4102/sajip.v40i2.119

James, J. B., McKechnie, S., & Swanberg, J. (2011). Predicting employee engagement in an age diverse retail workforce. *Journal of Organizational Behaviour, 32,* 173–196. http://dx.doi.org/10.1002/job.681

Kenny, M. (1987). The extent and function of parental attachment among first-year college students. *Journal of Youth and Adolescence, 16,* 17-29.

Kins, E., & Beyers, W. (2010). Failure to launch, failure to achieve criteria for adulthood?. *Journal of Adolescent Research, 25*(5), 743-777. doi:10.1177/0743558410371126

Luzzo, D. A., & Day, M. A. (1999). Effects of strong interest inventory feedback on career decision-making self-efficacy and social cognitive career beliefs. *Journal of Career Assessment, 7*(1), 1-17. doi: 10.1177/106907279900700101

McAuley, M. J. (2003). Transference, countertransference and mentoring: The ghost in the process. *British Journal of Guidance & Counselling, 31*, 12–23. doi:10.1080/0306988031000086134

Moore, D. (1987). Parent-adolescent separation: The construction of adulthood by late adolescents. *Developmental Psychology, 23,* 298-307.

Philips, B., Wennberg, P., Werbart, A., & Schubert, J. (2006). Young adults in psychoanalytic psychotherapy: Patient characteristics and therapy outcome. *Psychology and Psychotherapy: Theory, Research and Practice, 79,* 89–106.

Piaget, J. (1971). The theory of stages in cognitive development. In: D. R. Green, M. P. Ford, and G. B. Flamer (Eds.), *Measurement and Piaget* (pp. 1–111). New York: McGraw-Hill.

Piaget, J. (1985). *The equilibration of cognitive structures: The central problem of intellectual development*. Chicago: University of Chicago Press.

Ramani, S., Gruppen, L., & Kachur, E. K. (2006). Twelve tips for developing effective mentors. *Medical Teacher, 28*(5), 404–408.

Reeve, J., & Jang, H. (2006). What teachers say and do to support students' autonomy during a learning activity. *Journal of Educational Psychology, 98*(1), 209 –218.

Roche, G. R. (1979). Much ado about mentors. *Harvard Business Review, 1,* 14–31.

Ryan, R. M., Deci, E.L., & Vansteenkiste, M. (2015). Autonomy and autonomy disturbances in self-development and psychopathology: Research on motivation, attachment, and clinical process. *Developmental Psychopathology*.

Ryan, R. M., & Lynch, J. H. (1989). Emotional autonomy versus detachment: Revisiting the vicissitudes of adolescence and young adulthood. *Child Development, 60,* 340-356.

Schaufeli, W., & Bakker, A. (2003). UWES Utrecht Work Engagement Scale: Preliminary manual (Version 1). Retrieved June 11, 2013, from www.arnoldbakker.com/articles.php

Schaufeli, W. B., Bakker, A., & Salanova, M. (2006). The measurement of work engagement with a short questionnaire. *Educational and Psychological Measurement, 66*(4), 701–716. http://dx.doi.org/10.1177/0013164405282471

Segrin, C., Woszidlo, A., Givertz, M., Bauer, A., & Murphy, M. T. (2012). The association between overparenting, parent-child communication, and entitlement and adaptive traits in adult children. *Family Relations, 61*(2), 237–252. doi: 10.1111/j.1741-3729.2011.00689.x

Segrin, C., Woszidlo, A., Givertz, M., & Montgomery, N. (2013). Parent and child traits associated with overparenting. *Journal of Social and Clinical Psychology, 32*(6), 569-595.

Simpson, M. (2009). Predictors of work engagement among medical-surgical registered nurses. *Western Journal of Nursing Research, 31*(1), 44–65. http://dx.doi.org/10.1177/0193945908319993

Spencer, R. (2007). "It's not what I expected": A qualitative study of youth mentoring relationship failures. *Journal of Adolescent Research, 22,* 331–354. doi:10.1177/0743558407301915

Steinberg, L. (1990). Interdependency in the family: Autonomy, conflict, and harmony in the parent adolescent relationship. In S. Feldman and G. Elliott (Eds.), *At the threshold: The developing adolescent.* Cambridge, MA: Harvard University Press.

Von Culin, K., Tsukayama, E., & Duckworth, A. (2014). Unpacking grit: Motivational correlates of perseverance and passion for long-term goals. *The Journal of Positive Psychology, 9*(4), 306-312. doi: 10.1080/17439760.2014.898320

Psychology versus Therapy: Implications for the Practice and Supervision of Therapy in Residential Treatment and Wilderness Therapy Programs

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Abstract

This paper explores clinical practice with adolescents, young adults, and their families in a residential or wilderness therapy setting. The purpose of this paper is to present an approach to clinical practice and clinical supervision that is based on attachment and psychodynamic theories. Transference, countertransference, advice-giving, containing, and suggestions for practicing therapy and clinical supervision are explored. This paper will contrast "problem-solving" therapy and supervision with therapy and supervision that facilitate the development of the self.

Keywords: adolescent therapy, residential treatment for youth, family work for youth in therapy, family therapy, adolescent substance abuse, adolescent mental health, attachment theory, psychodynamic theory.

When we began our career as wilderness therapists, we were armed with clinical training and a passion for helping young people. Like many young therapists, we were eager to make a difference. It was our hope to offer adolescents some of our hard-earned wisdom. Similar to many young adults starting a career in a helping profession, we thought we had made it through the refining fires of childhood and arrived to help others achieve the same success.

During our education and training, professors warned against assuming the "expert-position," and we never quite grasped the concept. The experienced therapist realizes that they are not an *expert on the client's truth* and that some of the best learning on the part of the client comes from mistakes, meandering, and running into the proverbial wall. The following discussion will explore the *process* of therapy and the role of therapists. We will examine the difference between the study of psychology and the application of it in the therapeutic process. Specifically, countertransference and containing will be clarified in order to explain the issues affecting treatment in therapeutic programs and schools. Last, implications for the supervision of therapists and clinical staff will be presented.

General Discussion

Psychology is the study and science of human behavior. Any student or lay person can memorize psychological terms, perform techniques and interventions, and offer a diagnosis without training. Unfortunately, graduate students are often guilty of prematurely practicing psychology on unsuspecting family and friends after only a few classes. Yet the knowledge of psychological sciences and its blunt application is not therapy; therapy is something different. *Psychology informs therapy, but it is not therapy.* Therapy is a difficult process that requires great psychological and emotional capacity.

One could call the practice of applying terms, techniques, and theory, without the recognition of the therapeutic process, *doing psychology*. It may be evident in statements like, "You are in denial," or "You are rationalizing." In their frustration, and with an overwhelming sense of impotence at their ability to make behavioral change, therapists may claim, "his mother has borderline personality disorder," and

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"her unwillingness to receive feedback is evidence of her resistance." These labels and assumptions often bespeak the clinical staff's frustration and may ultimately serve to ensure that the therapist does not encounter their own self, which may lie buried deep in the unconscious in order to preserve a sense of likability. While labels can be a shorthand for therapists to identify patterns of defenses in clients, they are often used to excuse the therapist from the equation. Miller (1979) suggests the idea that therapists may cloak their disapproval and derision behind abstract terms like 'borderline,' 'obsessive,' 'regression,' 'destructive,' but unless they are willing to explore the three-year-old girl or boy inside themselves, they may not see the parallel between these terms and garden variety contempt.

Similar to a therapist *doing psychology,* a client may engage in using therapeutic tools and skills in defense of their ego; this can be referred to as "weaponizing" therapy. These clients use tools and terms to attack others and defend themselves against perceived threats. Lerner (2005) refers to this as "the obnoxious phase"; rather than owning feelings, clients may project out their limitations or "badness" externally, since these presences are threats to the ego. However, when skilled therapy can be integrated, clients gain the ability to support themselves with these new concepts and tools without defending themselves and attacking others.

Melanie Klein, a leading innovator in Object Relations Theory, described two phases of human development. The first of these is the *paranoid position.* In this state the individual sees the world and others "out there" as a threat. A child does not have the psychological structure to incorporate negative feelings, so they project them out into the world and see them as outside of themselves. Though the paranoid position is normal during the childhood years, it can continue into adult life, when its impact becomes especially problematic. The second, more evolved position, is the *depressed position;* in this position the individual is able to incorporate and integrate the negative feelings into the self. Now badness and conflict can be internal and the person is able to see that they may hold some part of the conflict they once perceived to be external. Rather than a parent in the paranoid position who drops a child off with the therapist and asks them to "fix them and call me when you are done", the parent in the depressed position participates in the process with the understanding that each family member plays a role in the identified patient dynamic (Spillius & O'Shaughnessy, 2012).

Therapists who can assume the depressed position do not relegate the problems in the therapeutic progress solely to the client, but rather they ask themselves, "What am I missing and how might I be failing the client?" When the client complains to the therapist they respond with, "Thank you for telling me, I am so sorry I missed that; I am glad you are telling me and I am honored you would share your feelings with me." Clients' resistance, no matter how severe, should not preclude self-examination on the therapist's part.

The following story illustrates these two positions. Recently, during a parenting class, a parent asked about allowing children to swear noting, "I don't like it when my child swears at me. Is it okay to require them to express themselves in more respectful language?" One of the authors teaching the class responded, "I can't speak for you and your boundaries, it is not up to me to tell you what you should and should not allow. For me as a parent, it really comes down to my capacity at that moment. If my daughter yells at me, 'F--- you, Dad!' and I am in a grounded place, I will hear her pain, anger and frustration. I will respond quietly, patiently and with empathy. If I am depleted, I am likely to lecture her about 'respect' and 'appropriate language.'" The latter response may be evidence of a lack of capacity in that moment, resulting in placing blame on the child. The former response demonstrates capacity to "see" the child and to hold space for them. In *The Misery of the Good Child*, (Gill, 2015) we see this profound distinction:

> All persons have limits. Consequently, all parents have limits. It is routine for us to discipline or punish our children when they exceed our limits. Unconsciously our goal in doing this is to get them to behave in ways we can more easily tolerate and manage. Besides it makes our load lighter. It is routine in these interactions for us to feel we are helping the child by our actions. They can't just go around upsetting people. The world, after all, has limits, and the child needs to learn about these.
>
> This is a way of saying parents have different bandwidths of what they can and cannot handle. Some parents are extremely rigid and can only manage little breadth. Some, on the other hand, can manage a wide range with seeming ease. From the child's perspective,

> however, the picture is not so clear. First of all, the child picks up a mixed message. The over the table message is "this is for your own good." The under the table message is "this is my limit; I can't go any farther." That is, the parent is being incapable. What now? The child is likely to be puzzled if not frightened (p. 7-8).

A parent with very limited bandwidth operating from the paranoid position creates a dynamic where the child internalizes the message, "I am too much." In this internalized state, the child perceives that they are unacceptable and unlovable. The child is asked to carry the parents' expelled badness and is left with an internalized sense of badness and shame. It should be noted that children do not need parents (or therapists) with limitless capacity. If this were the case, then all children would be doomed since no parent is fully capable. What the child needs is a parent who can own their own limitations, "I cannot do this right now," "I am uncomfortable," "This is too much for me and I need a time-out."

Our limited capacity is where boundaries originate. Boundaries are not to change the "other". Recently a colleague asked one of the authors, "How good are you with boundaries?" He followed with, "For example, if a client called you on a Sunday morning, would you avoid returning their call and be able to teach them good boundaries?" At that point, the question shifted in a fundamental way. It became clear the question was more about a therapist's capacity. The author replied, "I do not set boundaries to teach others' lessons. The wife of the alcoholic does not leave her husband so he will stop drinking. She leaves him because she does not want it in her life anymore. If I could answer the phone and it did not take away what I needed, I would answer it. If I could not adequately take care of myself and take the call, then I would let it go to voicemail." It is important to consider the principles of healthy boundaries in relation to therapist capacity. With time, insight, and internal work, a therapist's capacity can be enlarged.

Complaining about clients' pathology is ironic at best, and abusive at worst. Clients are coming to us because they are wounded. Clients are coming to us because their level of functioning is such that their lives are impaired. To hold them with compassion and patience is our job, and it is our obligation to recognize our limitations in that process.

Many of our clients come from homes where parents replayed the way they had been treated as children. These parents, unaware of their own context, pass on this legacy by requiring their children to conform to a way of being that they find tolerable. "It may be seen the children from each of these homes emerges with a different base of experience in terms of which to experience, interpret, and cope with the world in which he or she functions. Clearly, topical solutions do not impact such a base" (Gill, 2016). Therefore, therapy should be a new experience; this goes far beyond *doing psychology* and making behavior change. Therapy attempts to repair the self.

The Process of Therapy and Countertransference

The therapist's capacity is illuminated by their reaction to the client, and this reaction is what is called countertransference. It isn't simply that a client may remind the therapist of their mother or a bully from grade school; the themes of countertransference are subtler and more insidious. They may be manifested in discomfort with the client's real self. Often, therapists frame this discomfort in ways that may, at a surface level, sound like concern for the client, while underneath exists a disapproval of the client. We talk about feeling hurt, sadness, and frustration for the client's behavior or feelings, suggesting that it is for their own good that they change. Sometimes we may justify discharging our feelings towards the client, because we want them to know how they are affecting others. Yet, it is possible that in these cases, we may be acting out of our own limited capacity and our own countertransference. In that case, intolerance tends to activate a child's splitting and projection, so that they remove from consciousness any trace of the parts of themselves that are intolerable to the therapist (Gill, 2016). If a client who was not allowed to be a whole self in order to preserve parental approval, encounters a therapist with a similar background, level of capacity, as well as unresolved countertransference issues, the therapist may be unable to provide a corrective experience. The worst case scenario in this case is that a therapist will become an agent for the parents in responding to the client with the same kind of reactions that caused the original wounds.

Early ideas of countertransference saw it as something to be avoided, but modern views of countertransference see it as unavoidable and even valuable (Gill, 2016). With the latter idea, the

therapist makes diagnostic use of the countertransference: "I am anxious, I wonder why; I wonder if my client is afraid and I am taking it on; "I am frustrated with this client, I wonder if I am being engaged in a power struggle that can teach me about my client's context." The therapist can wonder privately or aloud, disclosing to the client their feelings in an attempt to explore the origin with the client. This disclosure is not merely a therapist projecting onto the client their feelings, but one of ownership. "I am feeling scared or worried right now. I think I am having the urge to fix you, which comes from my past. I am sorry. I was losing contact with you and I think I was starting to try to fix it. Does that resonate with you? What is your reaction?"

Therapists can gain insight into their countertransference issues as well as make changes in their manifestation thru the use of supervision and their own therapy. For example, since narcissism shows up as inflation, it can trigger therapists to want to "put the narcissist in their place." In response, the narcissist client is likely to reject the therapist's approach because it does not reinforce their sense of grandiosity. Or, the therapist may experience the narcissistic client as seeing themselves as better than others, which may trigger the therapist to deliver the client a reality check calling them on their "stuff" and taking them down a notch. The therapist's response can include anger, disgust, judgment and hatred. See the problem? Though we most likely don't intend it, we are responding to a wound by reinjuring the one suffering from the wound. The wound is the narcissistic injury: a lack of connection and attachment in childhood. The treatment requires that we stay connected to them and this requires capacity and the ability to manage our own countertransference.

An example with an aggressive client may also prove helpful in illuminating the concept of countertransference. If an aggressive client scares us and we attempt to eradicate their aggression without understanding the purpose it served in their development, we are doing nothing different than was done in their childhood. In therapy, the client unconsciously "attempts to establish the past in the present. This is what Freud called the 'transference neurosis'" (Gill, 2016). In this case the therapist can realize that the countertransference experience of fear of the aggressive client is the desired outcome of the aggression. The therapist's fear marks a moment of therapeutic opportunity for healing and insight, because it is the very feeling the client is attempting to dispel. When this is realized, the therapist may respond with warmth and benevolent curiosity, rather than with aggression or fear. The therapist may explore the process happening in the "here and now" as well as the connections it has to the client's painful early relationships.

Most importantly, by exploring and acknowledging the countertransference, the therapist can avoid counter-therapeutic behaviors towards their client. Therapists who respond with anger or disgust towards the client, stating that this is merely evidence of the client's pathology, fail to understand that the struggle to maintain compassion, patience, and curiosity is informative about the therapist as well as the client. In other words, "My problem with my clients is *my problem*, not theirs." Waning therapist capacity may result in frustration, anger, impatience, anxiety and emotional exhaustion that can be directed towards the client. Furthermore, a therapist already well-equipped with psychological labels may unintentionally distance themselves from the client to preserve their place in the paranoid position.

So what can we do as therapists to develop more bandwidth? Therapy requires great capacity. Therapy requires the therapist's transformation and enlargement and begins with the therapist's ability to see their countertransference. Hollis (1998) noted that Mahatma Gandhi once remarked, 'A coward is incapable of exhibiting love; it is the prerogative of the brave.' Projection, fusion, 'going home,' is easy; loving another's otherness is heroic. If we really love the "other", as "other", we have heroically taken on the responsibility for our own individuation, our own journey. This heroism may properly be called love" (p. 57). Loving the "other" as "other" in the person of the client is the essence of therapy.

Again, countertransference is not innately a liability. Countertransference is the therapist's feelings towards the client; or more specifically, the therapist's entanglement with the client. Many therapists are happy to assume the position of the expert or "guru," and make the mistake of providing advice and answers to questions that suggest they know the truth for their clients. However, the "helpful therapeutic experience is NOT just to be told [things], but to have a different kind of experience. This allows the [client] to discover a whole different kind of self than who he or she was" (Gill, 2016).

If not an expert, then what is the therapist's role? The key concept is that the therapist is *not an expert*

on the truth for their client, but they can be an expert for identifying a process to help the client discover their own truth. The inexperienced therapist might take the position, "I am a good person and I am successful, therefore I will share my wisdom with my clients. I will become their teacher and their advisor." Gill (2016) criticizes therapy for this approach and noted, "Therapy has become problem solving rather than a process of discovery of the self. The discovery of self is not fostered by offering advice or answers, but rather by asking better questions. Gill (2016) refers to this advice giving form of therapy as *abuse*:

> The therapist or guide we choose must not duplicate the wounds of the past. Thus, if the therapist or guide knows what is right for us and manipulates us to achieve these "treatment goals," it is abuse plain and simple. It is hard to see how good abuse ever cures bad abuse.

On the other hand, if the therapist can assist the client in discovering the barriers to discovering their truth, the client is provided an enduring source of truth. Shame and guilt, fear and anxiety, stemming from earlier contexts are addressed and the client is given access to the most powerful source of truth, themselves (Reedy, 2015). Therefore, ideally the therapeutic process is the discovery and development of the self of the client.

To assist clients via the therapeutic process, a therapist must understand the space they occupy in the relationship. Furthermore, to understand the space they occupy they must come into greater contact with themselves, which ideally occurs through their own therapy or supervision that asks them to look at themselves in relationship to the client. In this process, they must come into contact with their own darkness in order to understand the darkness of others. In order for the therapist to be able to provide adequate containment for the client, they must be able to provide a context where the whole self is allowed to emerge, rather than just the tolerable portion they were allowed in their background. If they have no sense of their wounds or their limitations, they won't be able to provide an adequate container for the client to discover their own context. An effective "container" is a place where one feels safe to explore all the parts of themselves free from judgments. In this way the "container" is the mind of the therapist (Reedy, 2015).

When a therapist is able to "hold" the client, without fear or dread, without anger or abandonment, the client is able to explore and find themselves in what their earlier contexts would not allow. Therapy is then considered not the exchange of information, but an experience where the client is allowed to feel and be. This experience can lead to healing rather than simple symptom reduction or sublimation.

Part of the business of psychotherapy is to discover and create alternate experiences for thoughts, feelings, attitudes, and beliefs. This is undertaken in the service of freeing people to be able to re- experience themselves in a safe but different context. The virtue of talking to an empathic and accepting person who has a different base is that it quickly illuminates one's own. What was automatic and unconscious is noticed and discussed. The world is allowed to become one of noticeable constructions (Gill, 2014).

Some therapists, especially novice therapists, might be inclined to cling to techniques. "Evidence based" practices can excuse a therapist from the equation and preserve a quality of untouchability; with this practice, no fault shall be ascribed to the therapist if progress isn't made. Therapy can be a terrifying place where the therapist may fear they will be discovered as a fraud. When a client has some kind of pathology, the therapist may begin to measure their worth in their ability to rid the client of complaints and symptomology. And when the client is resistant, rather than seeing the value of those defenses and honoring them, the therapist may feel the need to dispel them. Of course, attacking and ridding the client of earned defenses will evoke terror in the client, and so the battle for safety begins: the therapist tearing down the walls and removing symptoms and the client building them back up even stronger as the threat of the intrusion is great. Mitchell (1997) describes the expertise of a therapist this way:

> "The emphasis is not on behaviors but on rigorous thinking, not on constraints but on self-reflective emotional involvement, not on the application of general truths but on imaginative participation. This suggests a very different sort of technique. The discipline is not in the procedures, but in the sensibility through which the analyst participates . . . there is no generic solution or technique. There is a great deal of disciplined thought in the skilled practice of clinical psychoanalysis, and continual, complex choices (p. 61)"

PSYCHOLOGY VERSUS THERAPY

Therapists are like the story tellers for a narrative that the client is unable to tell themselves. White and Epston (1990) base their therapy on the assumption that people experience problems when the stories of their lives, as they or others have invented them, do not sufficiently represent their lived experience. In this way, narrative comes to play a central role in therapy. We listen, and our capacity to listen comes when we have some clarity about our own story, so as not to confuse it with the client's. We listen, reflect back, and tell their story to everyone: parents and family, and other clinical staff. We hope to tell it so that everything that seems crazy, every symptom or pathological behavior, makes sense. We tell a story that asks others for something; it asks parents to write certain kinds of letters to their children and respond with certain accommodations. We tell a story that asks peers for understanding and compassion. We tell a story that asks clinical staff for specific support. And as we tell this story, the client hears it for the first time and begins to understand themselves. This understanding provides healing; this understanding is called attachment. Benjamin (1998) taught that the root of the self is found through another person. When we are found we can recognize ourselves, and this recognition may allow us to heal the wounds that are at the root of our symptoms. Therapy is not a place where we go to be "called on our stuff" or to be confronted. There is no talent in that; there is no healing in that. Therapy is not a place where we go to listen to difficult things, but rather a place we go to in order to share difficult things. One of the authors of this paper heard a therapist say to a client, "If you came into session and told me you were in love with a chicken, I would assume you would have a good reason and I would be curious." It is this kind of container that allows us to re-experience ourselves and rid ourselves of shame. And after shame subsides, we can see the wound with compassion and begin to heal.

Therapy is not a place we go for more information, but to receive a different response than the one we received in our earlier contexts—the home of our childhood. Therapy is a place we visit to be received completely, entirely without the need to take care of the therapist or an anxious parent. An adequate therapist responds to our warts, our wounds, and our symptoms with calmness, compassion, patience and curiosity. This therapist is not anxious or eager to fix or heal us, but rather is passionate about finding us. The therapist's need to feel adequate or be seen as adequate by others (i.e., parents, referral sources, employers, etc.) is not driving the process. When we are found, seen, and heard without the anxiety, anger, frustration, or disappointment we experienced in our earlier contexts, we come to believe that we are okay. We come to be able to look deeply into ourselves, beyond the judgments of our symptoms or diagnoses. We look into our wounds and our traumas with compassion and understanding; and in this we may heal.

Implications for Supervision

At times, supervision with a therapist begins, "I think things are going well with the client in the program, but the difficultly I am having is with the parent. They are resistant (or anxious, or neurotic, or narcissistic, or…) and they are getting in the way of the child's progress. I do not know how to get them to a place where they can be part of the solution." Applying what this paper has delineated, the supervisor might say, "What if the parent were your client? I hear they are getting in the way of your treatment goals, but they have their own wounds, and while they are not convenient to your goals of helping the child, their wounds and their defenses are earned." When the therapist reduces the parent to object status—someone who is in the way of their goals, the therapist is frustrated and seeks to find a way to manipulate the parent. However, when the therapist remembers to see others and hold them in their mind with compassion and understanding, with clinical training, the ideal response is much more accessible.

The theoretical frame proposed in this paper has implications for the approach to supervision for therapists and clinical staff. Within this frame, asking the therapists questions that explore their relationship to the clients is more important in supervision than offering a series of suggestions or techniques:

> Why are you struggling?
> What are you feeling? This might be how they are feeling?
> What is in the way of you seeing the client?
> Why do they need to change? Why are you so invested in them changing?
> What is your role in their life?

Many of the barriers to effective therapy can be found and resolved in the therapist. Tools and techniques are a small part of developing the therapist; we must work to help the therapist look into the issues that prevent them from being able to provide healthy containment. If programs do not have someone on staff who is capable of this kind of supervision, then it would be wise to outsource supervision. When encountering this type of supervision, the therapist may say, "But I am a cognitive behaviorist. Where is the research on this? Maybe this is just your approach and I am not inclined towards this model." In response, supervisees could note that the approach is grounded in attachment research and theory and the effects of a healthy attachment figure on trauma and the development of pathology (Siegel & Hartzell, 2004). In addition, no matter the theory (Cognitive Behavioral Theory, Dialectical Behavioral Therapy, 12-step, Acceptance and Commitment Therapy, etc.), if the therapist is not clear about their role and relationship in therapy, the risk of doing harm is greater. If a therapist is able to show up with compassion and understanding, their tools and interventions will almost always be right. If the therapist shows up with judgment and condescension, it is impossible to do the work well; and one cannot fake it. The unconscious or unspoken feelings of the therapist are felt by the client, and there is no technique that can make up for these feelings.

So many therapists and programs think it is their job to help the child hear their parent's pain in the hope that self-defeating behaviors will cease. We ask parents to tell children how hurt, scared, and sad they are with their child's behavior. We assign children as the keepers and containers, suggesting their parent's serenity is their job. As we have visited other programs, therapists are often surprised by the teachings and process outlined in this paper. Some become defensive and outline their idea, their fantasy, that we are not (at least at times) providing "good abuse" to try to repair bad abuse. "Why hasn't anyone told us about this stuff before?" they ask.

Recently, while training a young clinical assistant using countertransference concepts, one of this paper's authors suggested, "You won't hear much of this in graduate school. I heard very little of it myself."

"Why?" She exclaimed. "This seems like the first thing they should talk about?"

"Why do you think?" I asked. "What would this require of a professor to be able to speak on this subject?"

"They would have to do their own work," she realized.

In addition to having implications for supervision, this frame has implications for therapists' therapy. This approach suggests that programs provide stipends for therapy, therapeutic intensives, personal workshops and that the leadership in programs model the practice of attending therapy. Therapists could attend Al-non or Codependents Anonymous or Families Anonymous if money is a limiting factor. Most therapists suggest that healing and sustained change will not occur if the entire system is not treated. Surely that concept applies to the therapist and the clinical staff of our programs. If nothing else, therapy provides the provider with empathy for the client's position. Most importantly, therapy will become a place where the therapist comes into contact with their own fractured self. They will come into contact with their own childhood and realize that "their truth" is not "the truth." Then and only then can therapists provide clients with a context that is reparative rather than a recreation of each's childhood wounding.

Conclusion

When people ask what to look for in a therapist, a powerful answer is, "look for a therapist who looks for you." Therapists should be able to resonate with clients even when that resonance asks them to consider their own limitations. Therapists should do enough of their own work that they are able to see and tolerate their client's in their full selves. Therapists should welcome and even celebrate a discussion about how clients are not getting the type of support and help from them or how angry and disappointed they are in them.

The irony is that if we are not learning as much from our client as they are learning from us then we are doing it poorly. Effective therapy asks the therapist to transform and surrender. This surrender must occur over and over again. It asks the therapist to feel and to work. It reminds the therapist of

their wounds and of the real self. It is an honor to sit with people as they consider sharing their real-selves at the risk of receiving the same kind of rejection they received as a child. It can inspire us daily to look into our own darkness and to create that same kind of vulnerability in the search for our own *self*.

References

Benjamin, J. (1998). *The Bonds of Love: Psychoanalysis, feminism, and the problem of domination*. New York: Pantheon Books.

Gill, J. D. (2014). *Finding Human*. North Charleston, SC: Create Space.

Gill, J. D. (2014). *Forms of Life: And other essays*. North Charleston, SC: Create Space

Gill, J. D. (2015). *The Misery of the Good Child*. North Charleston, SC: Create Space.

Gill, J. D. (2016). *Mexico Papers*. Unpublished Manuscript.

Hollis, J. (1998). *The Eden Project: In search of the magical other (a Jungian perspective on relationship)*. Toronto: Inner City Books.

Lerner, H. (2005). *The Dance of Anger: A woman's guide to changing the patterns of intimate relationships*. New York: Perennial Currents.

Miller, A. (1997). *The Drama of the Gifted Child: The search for the true self*. New York: Basic Books

Mitchell, S. A. (1997). *Influence and Autonomy in Psychoanalysis*. Hillsdale, NJ: Analytic Press.

Reedy, B. M. (2015). *The Journey of the Heroic Parent: Your child's struggle and the road home*. New York: Regan Arts.

Siegel, D. & Hartzell, M. (2004). *Parenting from the Inside Out: How a deeper self-understanding can help you raise children who thrive*. New York: Tarcher/Penguin.

Spillius, E. B., & O'Shaughnessy, E. (2012). *Projective identification: The fate of a concept*. Hove, East Sussex: Routledge.

White, M. & Epston, D. (1990). *Narrative Means to Therapeutic Ends*. New York: W. W. Norton & Company.

Wilderness Survival Guide to the T-Test

Laura Mills, Ph.D.
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Abstract

Many programs that offer intensive experiential therapy for youths and young adults are part of a broad collaborative effort that explores the impact of treatment. This type of exploration has been made possible by the guidance of NATSAP leaders, but also by program-level dedication to collecting data on the health of our clients. These efforts have resulted in benefits that span evaluation-informed clinical dialogue, treatment planning, and agency decisions. Now is a great time to think about how else the data can expand knowledge in our field and how agencies can work with their own data to do so. This paper was designed as a fun, adventure-oriented explanation of one particular type of analysis, the *t*-test, which looks at differences between two groups (e.g., differences on depression scores between a treatment group and a non-treatment group). This paper also explains how this analysis can be easily accomplished in excel.

Keywords: youth treatment evaluation, outdoor behavioral health, research methods

Twenty-something years ago, I helped guide a group of twelfth grade students on a five day hike while my colleague helped lead a five-day canoe trip, both through Killarney Provincial Park in Ontario. The trip was a wonderful opportunity to gain leadership skills and enjoy Killarney's beautiful coniferous-deciduous blend that is striking against the backdrop of its many lakes and pink-white Canadian Shield. The students spent months planning the necessary details of their last adventure together before heading off to their myriad futures.

We had incredible warm, dry, sunny days coupled with chilly nights that begged for campfire. The students, who started out with diverse abilities for tripping, became increasingly cohesive and competent in the skills needed to reach our daily goals. Conversations became more thoughtful and reflective, and it seemed there was a general increase in self-confidence. My colleague agreed that her canoe trippers met each day with renewed excitement and she also sensed that they shifted toward higher self-confidence.

We wondered whether self-confidence was different between our two groups, but we didn't then have knowledge to resolve this curiosity. I would have appreciated being able to examine whether our curiosity played out in some measurable way, if self-confidence was *different* between the canoe and hike groups and whether confidence really did *increase* over the course of the trip. Of course, there is a way to answer these questions and I am excited to share this knowledge. In this paper, I will explain a simple approach to understanding differences between two groups and will provide simple steps for using excel to measure these differences. I first will explain what I mean by *'differences between groups'*. This actually refers theoretically to the question 'do two groups of scores come from the same population or are the averages of these groups different enough that they are probably derived from different populations.' I know it's not something we would say in conversation, but let me explain…

Imagine all the clients across North America who come to intensive experiential outdoor programs (shown on the right). This group is called a population of treatment-seeking clients. Suppose they all completed a tool that measured orientation skills. Some people would score extremely high and some extremely low, but the majority would score somewhere within these extremes and most would hover around the average score. As I'm sure you've guessed, I'm talking about a typical distribution of scores, or a bell-shaped curve. There are lots of scores in the middle of the bell-shape, and fewer and fewer scores as you get toward the tails.

Now, imagine how different everyone's score is from the overall average. If you estimated the average of *those* differences, you would have a rough estimate of the *standard deviation*, which is a measure of

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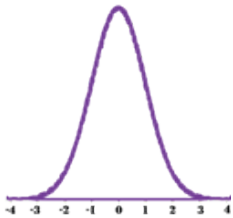
how much variability exists in a group of scores. The average and variability of a group of scores give us an idea about the population. We know approximately what most people in the group will score, give or take a standard deviation.

Think back to all the clients you have ever had in your program. These clients represent a sample of the population mentioned above. If they all completed a measure of orientation skills, you would have a sample with slightly different average and variability than the population, but it would likely be close enough to be representative of the population.

Now, say you have a colleague who has an intensive experiential indoor program. You think the colleague's clients might be a sample of people from a whole different population in terms of orientation skills. In other words, you think they are not from one population of clients who present for any type of intensive experiential treatment.

The *t*-test is a way to help us determine whether two samples are from different populations or if they are so similar that we can only assume that both samples are from the same population. But we must first consider how different everyone was on orientation skills, how variable they are. The *t*-test actually examines whether the two averages are meaningfully different, given how different scores are from person-to-person. Indeed, the *t*-test formula gives a ratio of the differences between group averages to the typical difference between individuals and the ratio is converted to a single number, the *t*-statistic.

This *t*-statistic, with an average of 0 and a standard deviation of 1(shown on the right), is compared to a distribution of scores similar to the bell-shaped curve discussed above. The amount of area above any *t*-distribution score tells us how likely it is, with the highest likelihood above the average, 0. The closer *t*-statistic is to 0, the less difference there is between the two average scores (given their variability) and thus there is a higher likelihood our two groups are from the same population. The more standard deviations away from 0, the lower the probability on the *t*-distribution. This means that the greater the difference between the two group averages (taking into account their variability), the less likely they are from the same population.



The *t*-statistic needs to be different enough from the 0 average of the t-distribution for us to say that the groups are meaningfully different. In many cases, more than 2 standard deviations from 0 difference is big enough to say that it's not likely the two samples are from the same population. However, the actual number that tells us with some certainty that our samples are likely from different populations changes with the number of people in the study. Therefore, we determine instead is the *probability* of our *t*-statistic.

We know the *t*-statistic is big enough to say that the two groups are likely not from the same population when it's probability, or *p*-value, is 5% or less. We can see from the distribution that the bulk of the scores hover between -1 and 1, so any number bigger than 1 or less than -1 will have a lower probability than those closer to 0, and likelihood decreases as numbers get further and further from 0. Lucky for us, excel has made it super simple to get this *p*-value. Once we know the *p*-value we can say, with some certainty, whether the groups are from the same, or different, populations.

I'll explain the steps to getting the *p*-value using my question about self-confidence between hikers and canoers as an example, and we can approach this just like it's a trip we need to plan and execute. Hopefully, you will conclude that doing statistical analyses can be as exciting and rewarding as any great adventure!

1. **Planning.** This is where the excitement begins and you start to envision the big picture of your adventure. Here, you need to determine the question you want to ask and administer a tool that aligns with that question. My question is whether *confidence* is different between canoers and hikers. We need a numeric score for each person on confidence. Of course, we could look at any scores of physical, mental, behavioral, or relationship health that, ideally, is measured with a valid and reliable standardized tool.

2. **Packing**. Well, not everything is fun. We need to put our scores into excel in a specific way (shown below)

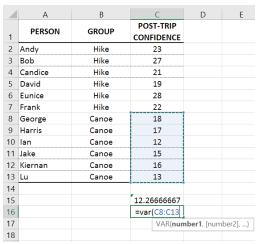
Each person has all their information on one row. For example, Bob was in the hike group and his confidence score was 27 after the trip.

PERSON	GROUP	POST-TRIP CONFIDENCE
Andy	Hike	23
Bob	Hike	27
Candice	Hike	21
David	Hike	19
Eunice	Hike	28
Frank	Hike	22
George	Canoe	18
Harris	Canoe	17
Ian	Canoe	12
Jake	Canoe	15
Kiernan	Canoe	16
Lu	Canoe	13

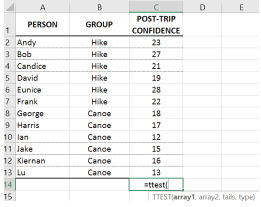
The top row is for titles

Each cell is filled with a VARIABLE, (something that is different for different people; it *varies*). People vary across scores, group association, name, etc.

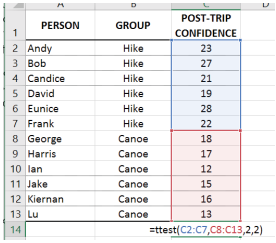
Just by looking at the data, it appears the hikers have higher self-confidence than canoers. But we can also see that almost all people have a different score, there is a lot of variability in the confidence of these trippers. We want to know if self-confidence for the whole group of hikers is meaningfully different than that for the group of canoers, given the person-to-person variability in scores.



3. **Backpack Weight Test.** Before we set out, we do need to check that things won't go awry because our packs are too heavy. One preliminary test we will do is determine whether the variability for the scores of each group are equal. In any empty cell, type **=var(** and select all the scores for one group, click enter. In another empty cell, get the variability for the other group. The two numbers can be considered fairly similar if their ratio to each other is less than 3:1. In our case, our variances are 12 and 5; we'll call them fairly equal.
4. **Setting Out.** We are ready for the first few steps of the trip. We can perform the *t*-test. In any empty cell, type **=ttest(**. Excel will automatically prompt us with clues as to what is next needed.



5. **The First Challenge.** We all know it, solving whatever problem arises, like wet boots and sore muscles, within the first hour. Like these problems, ours is an easy one. The Excel prompt **array1** is telling us to select all the scores for one group. Then we need a comma.
6. **Physical Obstacle.** You know this, it's like nature planned a nice easy obstacle for the group to tackle. The Excel prompt **array2** is telling us to select all the scores for the other group. Then we again need a comma.
7. **Decision Time.** Usually around mealtime, the team needs to make a decision, like what or where to eat. Here, we'll have an easy decision as well. The excel prompt **tails** is asking us to determine whether we want to see differences between the two groups regardless of which group is which, in which case we enter the number **2** and a comma. (A 1-tailed test is if we thought one group should have higher scores than another group).



8. **Finding Camp.** Everyone can breathe a sigh of relief and offload the gear. We are at the finish line. The Excel prompt **type** is asking us whether we are testing two groups or the same group over two times. We want two groups so we enter number 2 and close the bracket.
9. **Campfire.** My favorite part of any trip. Dinner done, everything cleaned and put away, and time to relax. We have everything we need. We can close our bracket and click **enter**.
10. **Reflection**. I feel like this is when the real trip begins, the time when we start looking inward and interpreting our experience. In our case, we can think about what excel has provided

for us, in this case, a number. For my example, the value is **0.00076**. This is our *p*-value and it's less than .05, so we know there is little chance that these two group scores are from the same population in terms of self-confidence, and the average for hikers was higher than that of canoers. My interpretation of this is that the two groups are different in terms of confidence. We can't say that this difference is caused by the trip, we just know that at the end of the trip the groups were not the same on this measure.

The other question we wanted to ask is whether our trippers increased their self-confidence over the course of five days. This requires more *pre-treatment* measures of confidence. Many of us are accustomed to administering various tools at program entry, which we will insert in a new column. Once entered, performing a test to see if scores changed over time is quite simple. I'll spare you the tripping analogy, now that you are comfortable with the excel steps.

1. Enter **=ttest(**
2. Select the set of scores taken before the trip, then put a comma.
3. Select the set of scores taken after the trip, and a comma.
4. The Excel prompt **tails** is asking if you want to test for increases or decreases in scores or both (we choose both, **#2**). Now a comma.
5. The excel prompt type asks what kind of t-test to perform and this time we want to choose paired, so enter **#1**. Now close the bracket.

Excel feeds us the *p*-value for the *t*-test, which in this case is .03. Since it's less than .05, we can assert that our scores from pre- to post-trip were not the same. My interpretation here is that confidence increased from pre- to post-trip for all students.

	PERSON	GROUP	PRE-TRIP CONFIDENCE	POST-TRIP CONFIDENCE
2	Andy	Hike	17	23
3	Bob	Hike	22	27
4	Candice	Hike	25	21
5	David	Hike	16	19
6	Eunice	Hike	25	28
7	Frank	Hike	12	22
8	George	Canoe	15	18
9	Harris	Canoe	16	17
10	Ian	Canoe	10	12
11	Jake	Canoe	11	15
12	Kiernan	Canoe	17	16
13	Lu	Canoe	14	13
14				=TTEST(C2:C13,D2:D13,2,1)
15				TTEST(**array1**, array2, tails, type)

We have walked through two types of *t*-tests, a between-groups test and a two-time-point test. One told us that two groups, one hikers and one canoers, were not the same in confidence at the end of their trips. The other told us that confidence increased over the course of a trip for all students. I hope you now have an idea of what it means to test differences between groups and will try it out in excel with your own program data.

Some amazing work is being done to show the benefits of our types of programs across North America. Our results give us amazing tools for treatment planning, therapeutic dialogue, and assessing outcomes. It seems a great time to build on this work by engaging with agency-level data and addressing the questions that spark the curiosity of clients, staff, and your other stakeholders. For example, you might want to know if depression scores for males are different than those of females at program entry, if trauma symptoms decrease over the course of a wilderness program, or if family functioning is different for girls than boys after a therapeutic boarding school experience. These questions, and many others, can be addressed for internal learning and dialogue, program improvement, and more broadly advancing knowledge.

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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.*

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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).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.

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Journal of Therapeutic Schools and Programs

The editors are pleased to announce two upcoming special issues.

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Qualitative or quantitative research, case studies, survey studies, theoretical pieces, and literature reviews are welcome. Instructions for authors can be found at www.natsap.org.

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Chief Editor:

Ellen Behrens, Ph.D.

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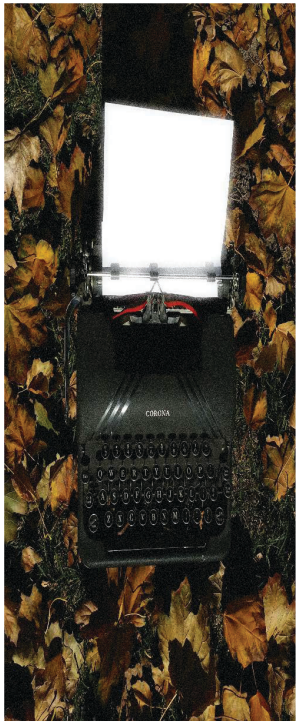

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The emotional and practical impact on families who have a member in treatment as well as long-term treatment outcomes.

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johns@montanaacademy.com

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NATIONAL ASSOCIATION OF THERAPEUTIC SCHOOLS AND PROGRAMS

2016-2017 Member Directory Order Form

To order a copy of the 2016-2017 Member Directory, please complete the form below and mail, email or FAX your order, with your check or credit card information for shipping and handling, to **NATSAP,** Inc.

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Please indicate your profession:

- ☐ Educational Consultant
- ☐ Psychologist
- ☐ Psychiatrist
- ☐ NATSAP Member
  Program Staff Member
- ☐ Parent
- ☐ Other _____(please specify)
- ☐ Licensed Counselor
- ☐ Licensed Therapist
- ☐ College/University Professor
- ☐ Alumnus
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Please select your NATSAP Membership Status:

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The National Association of Therapeutic Schools and Programs Ethical Principles

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

Therefore, all NATSAP member programs strive to:

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

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

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

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

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

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

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

8. Value continuous professional development, research and scholarship.

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

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

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

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

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

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