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Residential Needs of Adolescent Females: A Feminist Perspective

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Dedication

For Mark Steven Manley

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Abstract

With approximately 20,000 adolescent females living in residential treatment centers (RTCs) in the United States (Warner & Pottick, 2003), the need for RTCs that focus on meeting the unique developmental, psychological, and emotional needs of adolescent females is clear. Current research on the subject of adolescent females in residential treatment is largely focused on the overall efficacy of RTCs, rather than examining specific programmatic components offered to adolescent females in this treatment setting. While some research has been conducted that examines how to improve gender-specific RTCs, much of this research builds on socially constructed ideas of gender differences and often downplays the importance of race/ethnicity, class, and issues of sexual diversity that greatly impact adolescent female development (Goodkind, 2005). This study explored program demographics, issues of sexuality and development, relationship development, issues of trauma, and staffing. There were multiple hypotheses proposed before data collection. One hypothesis was that a higher number of services geared specifically toward adolescent females would be offered in gender-specific residential facilities as opposed to co-ed residential facilities. It was hypothesized that residential programs that have a higher number of staff members holding master's and doctoral-level degrees would provide a greater number of services for residents. The null hypothesis included that there was no relationship between the number of services offered for adolescent females and the type of residential facility (co-ed or gender-specific) where they received treatment, as well as that there was no relationship between the education of staff and the number of services they provided to residents. The results of this study found no significant correlations between gender-specific residential programs and the number of services offered. Additionally, no significant correlations were found between the number of staff members holding advanced master's and doctoral

degrees and the number of services provided to residents. Last, this study provided a thorough exploration of the services being offered to residents in adolescent treatment facilities in the United States. These findings will help to inform future research on the effectiveness of programmatic details.

Keywords: Residential treatment, females, adolescents, gender-specific treatment

Residential Needs of Adolescent Females: A Feminist Perspective

Research in the area of child and adolescent mental illness has grown steadily over the last decade, with the National Alliance on Mental Illness providing statistics that indicate that about 20% of youth (ages 13 to 18) experience severe mental disorders in a given year (Merikangas, Avenevoli, Costello, Koretz, & Kessler, 2009). While outpatient and intensive outpatient programs can often address mental health concerns for many adolescents, those with extreme emotional disturbances often need a higher level of structure, therapeutic care, and adult supervision than outpatient or intensive outpatient services can provide. These adolescents often end up in residential treatment centers (RTCs). There are currently an estimated 20,000 adolescent females living in RTCs in the United States (Warner & Pottick, 2003). It is alarming to discover that many models of RTCs were developed to meet the needs of adolescent males with delinquent and aggressive behaviors without careful consideration of the needs of adolescent females (Kirigin, 1996). While delinquent and aggressive behaviors may also be seen in adolescent females in RTCs, further research is needed to determine whether current RTCs meet the unique developmental, psychological, and emotional needs of adolescent females. To support further research on the effectiveness of gender-specific treatment, research first must determine what RTCs are currently offering in treatment.

This document includes an overview and operationalized definition of residential treatment facilities, as well as a brief review of the background and development of RTCs. An exploration of the current research is provided, as well as identification of the weaknesses in this research, particularly the lack of research on gender-specific RTCs.

General program issues that are often encountered in RTCs are also discussed. These issues include patterns of diagnosis, medication management, behavior management and

modification, life skills training and transitional programs, academic services, therapy services, peer counseling and mentor services, issues of trauma, and issues of sexual activity and development.

Staff issues that are often seen in RTCs are addressed within the literature review of this document. Staff issues include racial and ethnic representation of staff, de-escalation and use of restraints, and staff supervision and training.

The methods section of this document includes the survey items used in data collection, as well as an explanation of what each item or sets of items are designed to measure. This section also includes a statistical analysis of the data collected.

While RTCs lack a standardized definition, the American Association of Children's Residential Centers (Sternberg et al., 2013) defined residential treatment centers, as "an organization whose primary purpose is the provision of individually planned programs of mental health treatment, other than acute inpatient care, in conjunction with residential care for seriously disturbed children and youth, ages 17 and younger" (p. 47). RTCs offer a variety of mental health and skill-building areas of treatment. These programs may include behavior management training, life skills training, special education, and medication management in a highly structured environment. Many RTCs also offer individual, group, and family therapy. While RTCs are not licensed as hospitals and are generally less restrictive than inpatient hospitalization programs, staff members often monitor clients 24 hours per day (Bettmann, Olsen-Morrison, & Jasperson, 2011).

While adolescents with mental health issues that are severe enough to warrant residential treatment are faced with obvious challenges, adolescent females in RTCs take on additional challenges that are unique to their gender, socialization, and cultural expectations. Adolescent

females in the United States currently face substantial cultural challenges while they navigate the road toward adulthood. While it was beyond the scope of this study to provide an exhaustive examination of all of the unique challenges that adolescent females face, several themes appear continually within feminist psychology literature. Research has identified common themes that include an emphasis on resolving self-esteem issues internally (Goodkind, 2009) and issues of sexuality and the cultural double standard that women experience (Jordan, 1987). These themes and others are explored in greater detail in the literature review.

Although research in the area of RTCs for adolescents has grown significantly over the past few decades, the majority of these empirical studies have been focused on the overall efficacy of RTCs, rather than reviewing the specific programmatic components that are needed when treating adolescent males or females. While some research has examined improving gender-specific programs, this research often builds on culturally constructed and socially constructed gender differences, "while ignoring or downplaying racial/ethnic, class-based, and sexual diversity among girls and women" (Goodkind, 2005, p. 52).

Much of the research that is available on gender-specific residential programs focused on adult women in RTCs and primarily addresses substance use and abuse. While this is a slightly different population than the one that this study addressed, it is likely that many of these findings translate to an adolescent female population in RTCs as well. Research has shown that women tend to stay in treatment longer and experience better outcomes when programs are specifically tailored to their needs. For example, Galanter, Egelko, De Leon, and Rohrs (1993) found that pregnant or postpartum women who abuse drugs tended to do better in programs that specifically addressed their needs. Another example of addressing the specific needs of a population can be seen in RTCs that do not require that women be separated from their children during treatment.

These programs have demonstrated higher retention and completion rates than those that are not designed to keep mothers and children together (Hughes et al., 1995; Stevens & Arbiter, 1995; Wobie, Eyler, Conlon, Clark, & Behnke, 1997).

It is important to note that current literature on gender highlights that viewing gender as binary is no longer as relevant or accepted as it once was. The current understanding of gender in the field of psychology acknowledges that gender exists on a spectrum, with each individual falling somewhere between entirely masculine and entirely feminine. In this light, a shift in RTCs will likely occur that de-emphasizes binary gender and shifts toward an overall approach that considers how individual gender expression and socialization around gender impact the wellbeing of clients in RTCs.

To address the current gap in the literature regarding the question of what RTCs are offering their female and co-ed residents, this research specifically focused on program details within RTCs that impact residents. As this population is often overlooked or ignored in the literature, evidence is lacking that supports that the specific needs of these individuals are being met. To assess and develop best practices in treating adolescent females in RTCs, we must first understand what is specifically being offered to them in treatment. As the number of adolescent females in RTCs continues to grow, this is an area of research that should not be ignored if the field of psychology hopes to continue to improve residential treatment for this population. The ultimate goal of this study was to take a step forward toward identifying what RTCs in the United States are offering residents. These research findings may help to discover whether the unique gender needs of adolescent females are being met and help to implement program changes to meet their needs better. These research findings could greatly contribute to any necessary changes within RTCs, which would ultimately benefit the population receiving

services through these organizations.

Several hypotheses were proposed before data collection. The first hypothesis was that a higher number of services geared specifically toward adolescent females would be offered in gender-specific residential facilities as opposed to co-ed residential facilities. It was also hypothesized that residential programs that have a higher number of staff members holding master's and doctoral-level degrees would provide a larger number of services for residents. The null hypothesis included that there is no relationship between the number of services offered for adolescent females and the type of residential facility (co-ed or gender-specific) where they receive treatment, as well as that there is no relationship between the education of staff and the number of services they provide to residents.

In designing the survey for this study, I worked to generate questions based on relevant research in the field, which is outlined in the literature review.

Literature Review

Residential Treatment Centers

RTCs gained popularity as a new approach to working with emotionally disturbed children and adolescents in the 1950s with an emphasis on treating serious psychiatric and behavioral disorders (Leichtman, 2006). The works of Bettelheim (1948, 1949), and Bettelheim and Sylvester (1948, 1949) were particularly influential during this period. These writings largely focused on the role of direct care and behavioral aides in implementing psychotherapeutic interventions with children and adolescents in RTCs, with a strong emphasis on psychoanalytic theory and interventions (Leichtman, 2006). RTCs filled a niche need by providing treatment options for children and adolescents who were too behaviorally challenged and/or mentally ill to be treated in outpatient therapy, day treatment, or intensive outpatient

programs. While inpatient psychiatric units are generally designed to manage short-term crises and psychiatric emergencies, residential facilities are tasked with focusing on treatment goals and are generally longer-term (Larzelere et al., 2001).

By the 1970s and 1980s, distinctions were being made between what distinguished an RTC from a hospital or inpatient unit. These differences were mostly centered on hospitals serving a population that required a higher level of care than RTCs and being staffed with doctors, nurses, and psychiatrists while RTCs were run by psychologists and social workers (Leichtman, 2006).

While RTCs were designed with the best of intentions for a niche population, they began to encounter criticisms entering the 1970s, which included issues with familial separation and reintegration (Barker, 1982; Whittaker, 1980), outcome data reflecting the loss of gains made while in treatment after leaving (Quay, 1979, 1986; Wilson & Lyman, 1983), and accusations of abuse and misuse of power (Leichtman, 2006; Stoline, Goldman, & Sharfstein, 2000). While the programmatic and outcome criticisms listed above are beyond the scope of this study, the literature and my own professional experience in RTCs indicate that they are often highly focused on behavioral reprogramming without considering the lived experiences and cultural context of the individual in treatment. This is particularly problematic in institutions, where societal roles and cultural norms and patterns are recreated and played out among and between the staff and residents.

General program issues. These are general program issues that may impact whether the needs of adolescent females are being met in RTCs. First, it is important to differentiate what an RTC is and is not. A primary difficulty with RTCs and one that presented difficulties in this study is the lack of an operationalized definition of an RTC. While RTCs have been clearly

distinguished from hospitals, there was (and continues to be) no strong agreement among professionals as to what an RTC is. At best, there are often similarities between programs labeled as RTCs such as behavioral modification, “milieu therapy,” and life skills or a psychoeducational component to treatment, but these concepts are rarely defined or assigned protocols for implementation (Kapp, Rand, & Dammon, 2015). While agreement on the structure and organization of RTCs has been an ongoing struggle, researchers do agree that RTCs are moving toward being integrated with other mental health treatment services, having increased family involvement, and involving formal aftercare plans (Chance, Dickson, Bennett, & Stone, 2010; Lieberman, 2004).

As there is no current widely-accepted definition of RTCs, I operationalized a working definition to fit the parameters of this study. For the purposes of this study, RTCs for adolescents are defined as either gender-specific to female residents or to both male and female residents (co-ed) ages 11 through 18. The author decided on this age range by examining two different factors. The first was that adolescence is defined as the period between the onset of puberty and the age of legal adulthood (age 18 in the United States; Kliegman, Behrman, Jenson, & Stanton, 2007). Given that the onset of puberty in females is generally between the ages of 10 and 11 (Kail & Cavanaugh, 2010), I defined adolescence as ages 11 through 18 for the purposes of this study. The size of these RTCs ranged from 4 to 150 residents who lived in treatment facilities in which the focus was alleviating mental health symptoms and/or correcting behavioral issues, as these issues are often found together. These programs may also have a substance use component to treatment; however, the substance use or dual diagnosis component must be in addition to mental health and behavioral issues and not the primary focus of treatment. I made this decision because substance use and abuse were not the primary focus of this study.

This study gathered data from programs that had only female residents or both male and female residents at the facility. As the primary focus of this study was on adolescent females, it was important to examine female-specific residential facilities. However, I also included RTCs that housed both male and female adolescents to understand better what services were being offered and if these offerings differed based on gender. I also included questions that helped to identify how many residents identified as transgender were in these RTCs. While it was outside the scope of this study to focus heavily on this population, this information could contribute to future research in the field of psychology, particularly as ideas and understanding about the complexity of gender identity have begun to shift. Future research on the treatment and experiences of transgender residents in RTCs is needed, as current research is extremely limited and highlights social rejection, harassment, transphobia, and physical and sexual violence toward this population within RTC settings (Lyons et al., 2015).

Important and unique aspects of RTCs are the psychological and behavioral issues that lead residents and their families to seek treatment at these facilities. Research conducted by Connor, Doerflor, Toscano, Volungus, and Steingard (2002) built on past research by working on describing the characteristics of children and adolescents who entered residential care. This 2002 study added to this research by providing a more specific examination of aggressive behaviors, gender differences in males and females placed in RTCs, and the medical needs of children and adolescents in RTCs. This research identified that the primary psychiatric disorders of child and adolescent residents were often ones that resulted in disruptive behaviors such as conduct disorder or ADHD (49%) while affective and anxiety disorders made up 31% of residents, psychotic disorders 12%, and other disorders (e.g., developmental, tic, personality disorders) 8% (Connor et al., 2002, p. 502). This study found that almost all of the child and

adolescent residents carried more than one psychiatric diagnosis (92%), “39% of the children had two psychiatric diagnoses, 32% had three diagnoses, 20% had four diagnoses, and 1% had five diagnoses” (p. 502). These variable psychiatric diagnoses may result in actions, behaviors, and psychological distress that prompt families or government agencies such as the Department of Children and Families to seek residential care. Individuals may exhibit behavioral issues at school, in the home, and in the community that are severe enough that they place themselves or those around them at risk. RTCs may also serve as step-down facilities for individuals moving from a higher level of care (e.g., psychiatric inpatient units, placement in juvenile detention) to help residents reintegrate into society while addressing mental health issues. The 2002 research of Connor et al. highlighted the incredibly complex psychiatric issues that children and adolescents in RTCs often present with, and emphasized the need for specialized and focused care.

Much of the research that has been conducted on the characteristics of youth entering RTCs has primarily focused on males; using all-male samples or using very small samples of females (Handwerk et al., 2006). The few studies that have examined gender differences found that males and females entering RTCs differed in a variety of areas. Connor et al. (2002) found that these differences included the following; “prior to entering residential care, females present more risk factors than males and are more often reported to have multiple family problems, out-of-home placements, eating disorders, and experience with physical and/or sexual abuse” (as cited in Griffith et al., 2008, p. 31). Research has also indicated that girls in residential facilities are more likely to carry a primary psychiatric diagnosis of affective and anxiety disorder while boys are more likely to carry a primary psychiatric diagnosis of disruptive behavior disorder (Connor et al., 2002). Along with differences in primary diagnosis, child and adolescent females

in residential facilities have been found to exhibit more internalizing and externalizing behaviors than their male counterparts (Handwerk et al., 2006). These gender differences found in RTCs have resulted in research that suggests that facilities that do not have program designs that take these differences into account are less likely to be able to meet the needs of both male and female residents (Connor et al., 2002). Additionally, Lieberman (2004) posited that gender-specific RTC program development is only the first step in providing appropriate care to adolescents, suggesting that all aftercare services should also be tailored to the individual's gender and accompanying needs.

Given the variety of behaviors and psychological struggles adolescents in residential facilities present with, it was important to this study to identify what the top priorities of RTCs were to identify whether approaches to treatment would vary. It was also important to add an additional way to differentiate programs that should not be used in data collection (e.g., programs primarily focused on substance use/abuse). An item was developed asking respondents to identify the top three foci of their program, with the following responses to choose from: (a) individual behavior change, (b) stabilization of mental health symptoms, (c) improved interpersonal relationship patterns, (d) reunification with family system, (e) improved academic achievement, (f) substance use treatment, and (g) an option for the respondent to write in a focus that was not listed.

Residential treatment centers generally offer a variety of services that are designed to meet the specific needs of the population they serve. These services vary depending on the goals and size of the individual facility.

Medication management. Given that many of the adolescents who enter residential care present with psychiatric symptoms and behavioral challenges (Duppong-Hurley et al., 2009), it is

unsurprising that many have a history of being prescribed or are currently taking psychotropic medications (Handwerk, Smith, Thompson, Spellman, & Daly, 2008). While the use of psychotropic medications should be carefully considered by the family and treatment team, research has shown that psychotropic medications, "effectively reduce mental health and behavioral symptoms, particularly in combination with psychosocial treatments" (Spellman et al., 2010, p. 152). Research has also shown that between 40% and 80% of children and adolescents who enter RTCs are taking psychotropic medications (Handwerk et al., 2008). Of the youths who enter RTCs taking psychotropic medication, up to 80% of them are prescribed 3 or more medications at the same time (Connor & McLaughlin, 2005). The controversy around prescribing psychotropic medications to young adults arises when research on adverse effects, as well as overall efficacy, is examined more closely. Much of the research on psychotropic medications has been conducted with adults, and while the findings have been generalized to young adults regarding medication efficacy, safety, and side effects, it remains unclear how well these findings actually translate (Vitiello, 2007).

While there are currently no widely accepted, evidence-based methods for managing psychotropic medications for adolescents in RTCs, best practice guidelines are helping to shape the care of this population. Research thus far indicates that a collaborative approach between psychiatric staff and behavioral staff that emphasizes increasing safety through collecting and analyzing behavioral data has been successful in reducing problematic behaviors and psychological symptomology and distress (Handwerk et al., 2008; Spellman et al., 2010). This approach naturally requires a high level of ongoing communication between residential and psychiatric staff, which is difficult to accomplish in an RTC that uses outside sources for the prescription of psychiatric medication. Likely, best practice guidelines for psychotropic

medication for youths in RTCs are best followed by RTCs that have psychiatric staff within the facility.

***Behavior management and modification*.** Behavior management and modification are often primary goals in RTCs, given that many adolescents enter these facilities with severe behavioral problems (Duppong-Hurley et al., 2009). Behavior modification programs are designed to decrease unwanted behaviors and increase desired behaviors using positive and negative reinforcement. Reinforcement may include points, rewards, or signs of status at the RTC. Behavior modification may also encompass the use of extinction or punishment to reduce unwanted behaviors (Martin & Pear, 2007). Many RTCs utilize behavior charts to track behaviors over various increments of time that often depend on how often clients need reinforcement for specific behaviors.

While this approach is highly effective in reducing disruptive behaviors (Chen & Ma, 2007), many who work from a person-centered psychotherapeutic approach have criticisms of behavior management and modification. These criticisms are largely around the belief that Rogerian or other person-centered therapeutic approaches seem to be in direct opposition to a therapeutic approach that only addresses behaviors. This study explored behavior management and modification, as well as whether behavior management occurs in combination with other therapeutic approaches.

***Life skills training and transitional programs*.** The ages of adolescents in RTCs places them in a unique area of development in which they are developing skills and preparing to enter adulthood. Due to this, many RTCs incorporate life skills training into the daily lives of their residents, and some offer additional transition programs that provide adolescents nearing (or past) 18 the opportunity to test these skills in a less structured environment while continuing to

receive support from staff. Research on the transition to adulthood indicates that the most desired life skills are money management, furthering education, and issues around gaining and maintaining employment (Mares & Jordan, 2012). Programs may help guide their residents in learning skills such as meal planning, grocery shopping, cooking, budgeting, and self-care.

Life skills training programs may also focus on life skills related to emotional and psychological functioning. For example, life skills programs may also work to strengthen critical thinking skills, decision making and problem-solving, communication skills and interpersonal relations, and self-awareness and empathy (Srikala & Kishore, 2010).

Academic services. Academic services provided by RTCs vary significantly from one facility to another. Since school attendance and achievement are major foci of this age demographic, most RTCs address academics in some way to comply with state laws concerning education and educational attainment in youth.

Some small RTCs provide no academic services and require that students attend a nearby public school. Given the nature of the psychological and behavioral struggles that many of these clients face, some RTCs provide a trained staff member to accompany residents to public school to provide support and behavioral redirection using individualized behavior plans. Individuals who demonstrate behaviors that may be too problematic for a public school setting may attend specialized behavioral or therapeutic schools located near the RTC. This study examined which academic services are represented by RTCs

Therapy services. The beneficial effects of evidence-based psychotherapy practices have been well documented over the past decade (American Psychological Association, 2006, 2012), and it is difficult to imagine an effective residential treatment center that does not facilitate access to therapy services for residents. The American Association of Residential Treatment

Centers (1999) reported that of the 919 (self-identified) residential treatment centers, 532 (58%) reported providing therapy services to residents within the program. Of this 58% providing therapy within the program, 89% reported providing individual therapy services, 91% provided group therapy, and about 50% provided family therapy services (Hockenberry, Sickmund, & Sladky, 2009). RTCs with fewer residents that do not support a full-time clinician often refer their residents to local therapy services to support the needs of their residents. It is likely that RTCs providing psychotherapy services at their facility have a higher commitment/attendance rate for therapy, which would increase the positive benefits of engaging in therapy.

Peer counseling and mentoring. Peer counseling and mentoring have gained increasing prevalence over the past few years, particularly as an intervention with the vulnerable youth population (DuBois & Rhodes, 2006). Research indicates that this is a promising intervention and that peer counseling and mentoring can be valuable assets to treatment, particularly for individuals in this population who have had little adult support during their life.

While further research is needed to examine outcomes and determine best practices for this population, peer counselors and mentors are particularly motivating to youths who feel that they can relate to those who are mentoring them. Research also indicates that mentoring and peer counseling can have a strong positive influence on identity development (Rhodes, Liang, & Spencer, 2009; Rhodes, Spencer, Keller, Liang, & Noam, 2006). Additionally, some researchers have posited that mentors and peer counselors can help to monitor the activities of their mentees and encourage them to spend time fostering positive relationships and avoiding negative ones (Blechman & Bopp, 2005). One key component to mentoring and peer-counseling services is the idea that, “strong mentoring programs for at-risk populations can not only help build a sense of trust in others, but that mentoring may encourage individuals to more readily accept other

support services" (Britner et al., as cited in Mares & Jordan, 2012, p. 1510). This study examined whether RTCs provided mentoring or peer counseling as part of their treatment.

***Residents*.** Given the unique environmental, cultural, and contextual factors that impact individual treatment, I believed that it was important to collect gender, race, and sexual identity data about residents. These data may be helpful in developing and implementing future research to address better the needs of adolescents in residential treatment centers.

Research indicates that race and ethnicity have traditionally played significant roles in mental health treatment disparities of African American, Latino, and Asian American children and adolescents (Austin & Wagner, 2010; Cook, Barry, & Busch, 2013). A 2011 study that examined the racial/ethnic differences of adolescents with major depression who utilize mental health services found that only 38% received any type of treatment for major depression, with only 29.7% receiving services from a mental health professional (Cummings & Druss, 2011). Given the numbers reflected in past data, it continues to be important to collect data that reflect the current utilization of services by different races and ethnicities. This survey requested information on the representation of American Indians or Alaska Natives, Asian, Black or African American, Native Hawaiian or other Pacific Islander, and Caucasian within each RTC.

Sexual activity and development. Sexual activity and development are primary developmental concerns for the age group represented in this study, which results in RTCs and staff needing to attend to issues that may arise related to sexual activity and development. Much of the research that addresses adolescent sexual activity related to RTCs is focused on the problematic sexual behaviors of child and adolescent sex offenders. I sought to better understand whether and how issues related to sexual activity and development were addressed in RTCs, particularly for adolescent female residents, who face issues that adolescent males do not.

This study examined access to birth control for residents as well as access to testing for sexually transmitted diseases. Research shows that, while the rates of unwanted pregnancies are falling, approximately 30% of pregnancies worldwide remain unwanted (World Health Organization, 2008), and that young women who have not graduated from high school are at a greater risk for unintended pregnancy (Brown & Eisenberg, 1995). Doctors highlight that adolescent reproductive health care stands apart from reproductive health care of adult women largely due to the need for increased preventative care (Hayon, Dalby, Paddock, Combs, & Schrager, 2013). Adolescent women are at a higher risk for the human papillomavirus as well as pelvic inflammatory disease, and pelvic pain and menstrual issues impact them in different ways than adult women. It is recommended that sexually active women be screened annually for chlamydia and gonorrhea; this is particularly important for sexually active adolescent females given that, "asymptomatic infection increases the risk for pelvic inflammatory disease (PID) leading to further risk of infertility, ectopic pregnancy, and chronic pelvic pain" (Hayon et al., 2013, p. 460).

Given that dating and developing romantic relationships are often a primary focus for adolescents, this study explored if and how parameters are set for residents around dating one another and/or dating outside of the RTC. This study also gathered information around whether staff members address issues of consent, coercion, and sexual decision making with their adolescent residents. Many of the youths in RTCs have a history of being exposed to and involved in unhealthy relationships with others (Connor et al., 2002), and it is likely that support from an RTC around navigating romantic and sexual relationships during adolescence would be beneficial to residents.

Another important aspect of sexual development for adolescents is an awareness and

understanding of their own sexual identity. Since identity development overall is a primary issue for this demographic, it is unsurprising that sexuality also has significant implications. While understanding and integrating sexuality into identity can be a challenge for any adolescent in an RTC, it is well documented that adolescents who do not identify as heterosexual report higher rates of suicidal ideation and suicide attempts than those who do (Silenzio, Pena, Duberstein, Cerel, & Knox, 2007). Given the risk factors associated with these adolescents, this study examined whether RTC staff were aware of and attuned to the needs of the residents who did not identify as heterosexual.

***Staff issues*.** Staff in RTCs are an important part of treatment, as they are spending a significant amount of time modeling prosocial behaviors, implementing behavior plans, and/or providing therapeutic services to residents. Given that RTC staff members have near-constant contact with the adolescents in their care, I believes that they likely have a significant impact on the treatment and care that residents receive in facilities. It is often up to the milieu or direct-care staff to implement the treatment plans designed by clinical staff that often have significantly fewer direct contact hours with residents. For this reason, staff in RTCs must receive training and support that helps them to carry out the goals of the program (Shiendling, 2008).

***Racial and ethnic representation*.** While the rate of diversity in the field of psychology seems to be increasing, the field has been predominantly White throughout history. The American Psychological Association released data reporting that 20% of doctoral degrees awarded in psychology were awarded to minority graduates, a 4.5% increase from 1998 (APA, 2009). While the number of minority graduates holding doctoral degrees in the field of psychology remains relatively low, many staff positions in RTCs do not require graduate-level degrees, which may increase the level of racial and ethnic diversity among staff. While statistics

on the racial and ethnic representation by direct-care staff in RTCs were unavailable, it is likely that racial representation by staff members is important for developing rapport, particularly with residents of the same race.

A substantial amount of research exists on the impacts of gender and racial differences between adult clients and their therapists; however, little research can be found on this topic as it applies to adolescent clients. A 2005 study that focused on the impact of gender and racial differences between adolescent clients and their therapists on therapeutic alliance found that same-gender client/therapist dyads reported stronger alliances and resulted in a higher likelihood of completing treatment. This study also found that racially matched client/therapist dyads reported a higher level of treatment retention. However, clients did not report a higher therapeutic alliance (Wintersteen, Mensinger, & Diamond, 2005).

Research indicates that African-American clients often prefer working with mental health professionals of the same race (Cabral & Smith, 2011; Townes, Chavez-Korell, & Cunningham, 2009). While clients may prefer working with professionals of the same race, research also indicates that outcome data vary in negligible ways and do not support same-ethnicity client–therapist dyads as an important indicator of therapeutic gain (Cottone, Drucker, & Javier, 2002).

It is important to gather data on the racial and ethnic representation of staff in RTCs to better understand the impact that this has on treatment. This study worked on adding to the existing data on representation by asking specific survey questions about the racial and ethnic representation of staff members in participating RTCs. This study also asked specific questions regarding multicultural competency training for staff in RTCs that will likely encounter residents from backgrounds other than their own.

De-escalation and use of restraints. The use of physical restraints during escalation or crisis situations in RTCs has long been a source of controversy within the mental health community. Physical restraint is often used in RTCs to ensure the safety of individuals who are harming themselves or assaulting staff or other residents (Day, 2002). Supporters of the use of restraints often cite that there are therapeutic benefits to the technique such as children learning to verbalize their distress and manage their own strong emotions (Sourander, Aurela, & Piha, 1996).

While the primary use of physical restraint is to ensure the safety of staff and residents, current research, "calls into question their effectiveness for reducing aggression and violence and raises concerns about the extent to which they promote the physical and psychological safety of residents and staff members, especially when used on adolescents" (Leidy, Haugaard, Nunno, & Kwartner, 2006, p. 339). While restraints are generally accepted as an intervention that occurs when all other interventions have been exhausted, research indicates restraints are often used before other interventions are attempted (Leidy et al., 2006). Additionally, research has indicated that restraints often have a significant impact on clients. A 2010 study identified four themes that included "negative psychological impact, re-traumatization, perceptions of unethical practices, and broken spirit" (Strout, 2010, p. 421).

Improper restraints have resulted in child, adolescent, and adult deaths in RTCs across the United States; however, it is difficult to locate numbers that accurately reflect these deaths due to issues with reporting (Rakhmatullina, Taub, & Jacob, 2013). Due to the potential psychological and physical risks associated with restraint use in RTCs, this study asked specific questions around the use of restraints, as well as restraint training for staff members in RTCs.

Staff supervision and training. One reality that many RTCs face is that many direct-care

staff members have limited formal mental health training and education. In fact, the largest number of staff "working in hospital- and community-based residential settings in the United States consists of paraprofessionals with a bachelor's degree or less" (Liberman, Hilty, Drake, & Tsand, 2001, p. 1331). Given the nature of the work that direct care and clinical staff often do in RTCs, it is unsurprising that staff training is often an integral part of effective treatment.

Staff training around safety and other protocols is often required for new employees and at regular intervals for established staff members. These types of training may include emergency and crisis response procedures, an overview of treatment plans for residents, incident reporting, privacy and confidentiality, documentation requirements, and de-escalation and restraint training. This training is often required to satisfy state requirements for operating a residential facility.

Many RTCs also provide additional training for staff on clinical topics that are relevant to their work with residents. This training may include specific mental health disorders, self-harm and suicide prevention, boundaries between staff and residents, family system problems, and ethical issues that may arise in RTCs.

Despite limited formal mental health training and education for many direct-care staff members, research indicates, "effective teamwork is associated with less staff burnout, more optimistic attitudes about rehabilitation, and better clinical outcome" (Srikala & Kishore, 2010, p. 345). This teamwork may be between direct-care staff, between direct-care staff and supervisors, or any combination of staff working to provide treatment to residents.

As with training, supervision in RTCs is a necessary and important part of providing effective treatment to residents. Supervision allows space for staff to both provide and receive feedback; process strong feelings about situations, residents, or other staff members; issues

related to burnout; and space to role-play responses to difficult behavior from residents. Staff in RTCs are often supervised by a senior milieu staff member who previously formerly performed direct-care duties and showed proficiency in his or her role. A clinical staff member, such as a therapist or clinical case manager, may also supervise direct-care staff (Shiendling, 2008).

I chose to collect data around the supervision and training that staff members in RTCs receive due to the significant impact that staff members have on the treatment and clinical outcomes of residents.

Trauma. Research has long reflected that the majority of youths admitted to RTCs have a history of trauma (Briggs et al., 2012; Jaycox, Ebener, Damesek, & Becker, 2004), with rates reported as high as 71% (Jaycox et al., 2004), with 92% of youths in RTCs reporting traumatic experiences also reporting multiple incidents of trauma, with a mean of 5.8 exposures (Briggs et al., 2012). Briggs et al. found that a higher rate of females had been exposed to traumatic situations than males and that females were also more likely to have experienced physical and sexual abuse.

It is well documented in the literature that individuals with a trauma history often require a trauma-informed approach to treatment and may respond differently to traditional treatment modalities (Boyer, Hallion, Hammell, & Button, 2009). As this can be an important aspect of treatment, this study collected data on the different types of treatment modalities utilized with clients in RTCs to understand better whether the needs of residents were being met. With such a significant portion of this population having been exposed to complex trauma, it is likely important for staff in RTCs to have training and knowledge around how previous trauma impacts residents and their behavior. This study collected data around staff training specifically focused on trauma and trauma-informed treatment.

This survey examined general program issues related to the demographics and treatment offerings of the residential facility, issues of sexuality and relationship development, staff supervision and training, issues of trauma, and trauma-informed treatment. Questions developed for the survey in this study are consistent with issues presented in the literature. Although issues of interpersonal and relationship development are covered more sparsely in the literature, I chose to make them a primary focus due to personal experience of employment in a residential facility for adolescent females. This previous work experience highlighted the importance of the development of healthy interpersonal relationships for adolescent females in RTCs.

Method

As there is no currently widely-accepted definition of a RTC, I operationalized a working definition to fit the parameters of this study. For the purposes of this study, RTCs for adolescents are defined as either gender-specific to female residents or to both male and female residents (co-ed) ages 11 through 17. The size of these RTCs ranged from 4 to 150 residents who lived in treatment facilities in which the focus was alleviating mental health symptoms and/or correcting behavioral issues. These programs may also have a substance use component to treatment; however, the substance use or dual diagnosis component must be in addition to mental health and behavioral issues and not the primary focus of treatment.

Study Design

This study used an online survey methodology to assess what services are being provided to adolescents in their care. Specifically, the author gathered and assessed data on program demographics, academic services, therapeutic services, treatment modalities, life skill programs, behavior management, racial and gender representation, issues of sexuality and sexual development, staff training and supervision, interpersonal relationship development, and issues

related to trauma. To support future research efforts on how well programs are meeting the needs of adolescent females, we must first collect data on what services programs are providing residents.

Participants

I recruited participants for this study by sending an email to program directors of RTCs who have been located using the American Association of Children's Residential Centers member directory and the National Association of Therapeutic Schools and Programs member directory. This email contained an invitation for research participation and a link to the online survey. To improve participation rates, participants were able to choose to enter a drawing to win a $50 Amazon.com gift card once they completed the survey. The contact information for the entry to win the gift card was collected separately after the survey had been completed and was not associated with participant responses on the survey to ensure confidentiality. I collected 46 survey responses from current clinical directors and program managers of adolescent residential treatment facilities.

Demographic frequencies. Table 1 provides a numerical representation of the demographic questions answered by participants during data collection. The gender identities of participants were as follows: 33% reported identifying as male (n = 15), 67% reported identifying as female (n = 31), and 0% reported identifying as transgender (n = 0). Concerning the ethnicities of the participants, 96% reported "White or Caucasian," (n = 44), 4% reported "biracial," (n = 2), 0% reported "Black or African American," (n = 0), 0% reported "Hispanic or Latino (a)," (n = 0), 0% reported "Asian," (n = 0) and 0% reported "Native Hawaiian or Pacific Islander" (n = 0). In terms of sexual identity, 91% reported being heterosexual (n = 40), 2% reported being bisexual (n = 1), 0% reported being queer (n = 0), 0% reported being gay (n = 0),

7% reported being lesbian (*n* = 3), 0% reported being pansexual (*n* = 0), and 2 survey respondents chose not to answer. Regarding highest degree achieved, 9% reported having a bachelor's degree (*n* = 4), 76% reported having a master's degree (*n* = 34), and 15% reported having a doctorate (*n* = 7). Concerning the location of participants' residential treatment facilities, 17% reported "USA Midwest (*n* = 8)," 20% reported "USA Northeast (*n* = 9)," 8% reported "USA South (*n* = 4)," 53% reported "USA West (*n* = 24)," and one respondent chose not to answer.

Measure

The measure was an online survey. While developing the measure, I gathered information using prior research conducted on a variety of issues pertaining to RTCs and issues of adolescent development. I also utilized my previous professional experience working in RTCs to aid the development of questions that would explore the potential strengths and weaknesses of these facilities. The measure consisted of 52 questions from 4 categories: 26 questions regarding demographics, basic programmatic information, and treatment offerings; 9 questions regarding sexuality and romantic relationship development; 10 questions regarding staff issues and training; and 7 questions regarding friendship development. Questions consisted of a combination of multiple-choice and fill in the blank response choices (See the appendix for survey items). Please see Table 1 for questions included in this survey.

Procedure

I emailed a request for research participation to program directors and managers of residential treatment facilities. This email contained an invitation to participate with a brief description of the study and a link to the electronic survey, which was hosted by rationalsurvey.com. Program directors and managers who chose to participate clicked the

provided link to the study and were directed to the informed consent page. This page provided information on the research as well as expected risks and benefits to the participant. Participants who consented to participate and met selection criteria were directed to begin the survey. The survey consisted of 52 questions and took an estimated 15-19 minutes to complete. All survey responses were anonymous and confidential. I collected data for 16 weeks and then closed the survey to participants. I then conducted all analyses using SPSS statistics software. Response alternatives appear in the appendix.

Statistical Analysis

One working hypothesis I had was that additional services and treatment modalities would be offered for adolescent females in gender-specific residential facilities as opposed to co-ed residential facilities. The null hypothesis stated that there was no relationship between the number of services offered to adolescent females and the type (gender-specific or co-ed) of residential facility where they received treatment. I hypothesized that RTCs that treated both adolescent males and females would have fewer services that specifically addressed the needs of females. To test this hypothesis, a Poisson regression analysis was performed to discover the relationships between services addressing academia, behavior management, sexuality/relationship development, and interpersonal functioning that are offered in co-ed and gender-specific residential facilities. In this analysis, the independent variables were the different residential treatment programs that participated in this study. The dependent variable was the number of program features that addressed the needs of adolescent females, for example, issues such as access to and education about contraception or psychoeducation on developing healthy romantic relationships.

Another working hypothesis was that residential programs that have a higher number of staff members holding master's and doctoral-level degrees would provide a greater number of services for residents. This hypothesis was developed with the knowledge that master's and doctoral programs require two to five additional years of education and are often highly focused on areas of study that would directly impact client care. These areas of study often include issues of trauma, child and adolescent development, various therapeutic approaches to treatment, and issues of cultural competency that should be considered in treatment. I hypothesized that this additional clinical experience and education would allow RTCs that employ a higher number of staff members with graduate degrees to offer a greater number of services within the RTC.

To test this hypothesis, a Poisson regression analysis was performed to discover the relationship between the number of staff members holding graduate-level degrees and the ability of these programs to provide additional services to adolescent females. In this analysis, the independent variable was the number of staff members in the residential facility holding a masters-level or doctoral-level degree. The dependent variable was the number of different services and treatment modalities offered in the program. For example, a program might attend to women's sexual health issues, specifically discussing issues of sexual consent and decision making, including themes of empowerment in their mission statement, and providing psychoeducation around developing healthy relationships with others.

The frequencies of different services, staff training, and relational issues addressed within residential programs helped to identify the areas of strength and weakness across various programs. This information was valuable in determining what changes could be made to current and future programs to best support the needs of adolescent females in this setting. This data collection also provided the building blocks for future researchers to examine outcome data

associated with how well programs are succeeding in meeting the needs of adolescent females in their care.

It was interesting and informative to examine and compare the number of services offered by programs with the number of advanced graduate degrees in the field of social work and psychology held by staff in the programs. The hypothesis considering graduate degrees was that residential programs with a higher number of staff members who hold a master's or doctorate in social work or psychology would also provide a greater number of services than RTCs with staff who hold fewer advanced degrees. The survey questions that examined this hypothesis included questions that explored the level of educational attainment by staff in facilities, as well as questions related to access to birth control and sexually transmitted infection screenings, discussion of consent and sexual decision making, and staff training on trauma-informed treatment approaches and training related specifically to adolescent female development.

Additionally, valuable information was gathered by examining demographic variables within program settings. For example, it was beneficial to better understand how the demographic makeup of residents compared to the demographic makeup of staff and program directors, particularly due to the impact that representation can have on the psychological processes of adolescents, particularly regarding ethnicity, sexuality, and gender representation.

Each question included in this survey allowed for the opportunity to discover interesting and valuable information about the current offerings of residential facilities to the clients in their care. As the landscape of mental health care changes, it is valuable to understand what variables impact the quality of care received by those in RTCs. It is also of value to simply better understand the ways that RTCs are struggling and succeeding in meeting the various needs of

this population to implement future changes to these programs. Each question on this survey also allowed for the opportunity to rule out or disregard areas of potential concern presented by this study. For example, if a large majority of the data reflected that concerns about the sexual development of adolescent females in RTCs are well addressed in treatment, this is likely an issue that does not need additional high levels of focus or concern by researchers, as it is currently being addressed. These discoveries have the potential for widespread impact in the area of residential treatment facilities treating adolescent females. These data could help inform changes to how RTCs treating adolescent females are structured and run, which could increase the efficacy of treatment and benefit adolescent females receiving these services.

Results

The purpose of this study was to learn more about the specific program offerings of residential treatment facilities in the United States. This information is needed to support future research efforts to determine the effectiveness of meeting the needs of adolescent females in their care. Another purpose of this study was to discover whether a relationship exists between the level of educational attainment by staff and the number of program and treatment options within the RTC. The final purpose of this study was to identify patterns in the strengths and weaknesses of RTCs across the United States to set the groundwork for continued research and program development to improve the services and better meet the needs of adolescent females receiving care in residential treatment settings. To determine the best practices in RTCs, we must first understand what RTCs are offering to support future research that would examine outcome data.

There were multiple hypotheses proposed before data collection. One hypothesis was that a higher number of services geared specifically toward adolescent females would be offered in gender-specific residential facilities as opposed to co-ed residential facilities. It was hypothesized

that residential programs that have a higher number of staff members holding master's-level and doctoral-level degrees would provide a greater number of services for residents. The null hypothesis included that there was no relationship between the number of services offered for adolescent females and the type of residential facility (co-ed or gender-specific) where they received treatment, as well as that there was no relationship between the education of staff and the number of services they provided to residents.

General Program Information

To explore information about the types of services and approaches offered in residential facilities, participants were asked to respond to questions about treatment focus, demographics of residents, services provided, and mission statement themes. It is important to note that several of the following responses have results that tally over 100%, as participants were able to choose more than one item.

Focus of residential facilities. Participants were asked the primary focus of their treatment facility; 83% responded "mental health treatment," 17% responded "dual diagnosis treatment," and 0% responded "substance use treatment." Participants were asked what the top three foci of their treatment program were; 70% responded "improved interpersonal relationships," 67% responded "individual behavior change," 65% responded "stabilization of mental health issues," 61% responded "reunification with family system," 28% responded "improved academic achievement," 4% responded "substance abuse treatment," 2% responded "family system issues," and 2% responded "trauma." It is important to note "substance abuse treatment," "family systems issues," and "trauma" were responses written in by participants and were not response options provided by the author.

Participants were asked what the primary reasons for residents seeking treatment were;

96% responded, “behavioral issues at home,” 89% responded “behavioral issues at school,” 89% responded “previous placement in a hospital psychiatric unit,” 80% responded “physical or sexual abuse,” 76% responded “behavioral issues in the community,” 63% responded “aggressive or violent behavior,” 59% responded “substance use/abuse issues,” 54% responded “removal from family system by the Department of Children and Families,” 43% responded “previous placement in juvenile detention,” and 26% responded “other.”

Resident demographics. Participants were asked how many residents were in their program; 13% responded “20 residents,” 11% responded “60 residents,” 5% responded “17 residents,” 5% responded “48 residents,” 2% responded “3,” 2% responded “145 residents,” 2% responded “44 residents,” 2% responded “33 residents,” 2% responded “16 residents,” and 43% of respondents chose not to answer this question. Participants were asked if their facility was gender-specific or co-ed; 54% responded “co-ed,” and 46% responded “gender-specific.” Participants were asked if their facility was co-ed, how many residents of each gender did they have; 25% responded “125 males, 0 females,” 25% responded “0 males, 20 females,” 25% responded “12 males, 4 females,” 25% responded “50 males, 50 females,” 9% responded to this question in a format different than the one requested by myself, and 79% of respondents chose not to answer this question.

Participants were asked how many of their residents identified as transgender; 35% responded “0 residents,” 22% responded “2 residents,” 17% responded “3 residents,” 11% responded “1 resident,” 2% responded “9 residents,” and 7% of respondents chose not to answer this question.

Participants were asked what age ranges their facilities treated; 11% responded “ages 0 to 5,” 13% responded “ages 6 to 10,” 35% responded “11 to 15,” 24% responded “16 to 21,” and

35% of respondents chose not to answer this question.

Participants were asked what races residents in their facility represented; 100% responded “Caucasian,” 96% responded “Black,” 52% responded “Asian,” 50% responded “American Indian or Alaskan Native,” 24% responded “Hispanic,” 2% responded “Korean,” 2% responded “East Indian,” and 2% responded “mixed race.”

Services provided. Participants were asked what services their programs provided; 98% responded “individual therapy,” 96% responded “family therapy,” 96% responded “medication management,” 93% responded “group therapy,” 89% responded “life skills training,” 89% responded “behavior management,” 78% responded “case management services,” 54% responded “transitional living program,” 37% responded “peer counseling,” 7% responded “other,” 4% responded “animal therapy,” 4% responded “parent support,” and 2% responded “trauma therapy.”

Participants were asked what academic services were provided by their facility; 80% responded “school on the premises,” 46% responded “tutoring on the premises,” 43% responded “staff member attends school with client,” 26% responded “clients attend public school,” 11% responded “clients attend an outside specialized/behavior school,” 4% responded “trauma-focused academic services,” 4% responded “other,” 2% responded “college prep,” 2% responded “no academic services offered by facility,” and 0% responded “clients do not attend school.”

Participants were asked if individual therapy was offered at their facility, what approaches were represented; 91% responded “cognitive behavioral therapy,” 54% responded “behavior therapy,” 52% responded “integrative or holistic therapy,” 50% responded “psychodynamic therapy,” 48% responded “Rogerian or person-centered therapy,”

9% responded “trauma-focused therapy,” 9% responded “eye movement desensitization and reprocessing therapy,” 7% responded “other,” and 2% responded “play therapy.”

Participants were asked if their residents participated in an exercise program; 100% responded “yes,” and 0% responded “no.”

Participants were asked if their program included a life skills component; 89% responded “yes,” and 11% responded “no.” Participants were asked if their program included life skills development, what components were included; 89% responded “cleaning/housework,” 80% responded “laundry,” 78% responded “time management/planning,” 67% responded “meal preparation/cooking,” 63% responded “meal planning,” 57% responded “budgeting,” 46% responded “grocery shopping,” and 26% responded “accessing public transportation.”

Participants were asked what behavior management techniques were used in their facility; 78% responded “natural consequences,” 63% responded “level system,” 30% responded “token economy,” 24% responded “other,” 24% responded “behavior charts,” and 7% responded “punishment.”

Participants were asked if their facility had a transitional living program; 61% responded “no,” and 39% responded “yes.”

Participants were asked if their facility had a dress code for residents; 67% responded “yes,” and 33% responded “no.”

Participants were asked if their facility allowed residents to participate in outside activities such as sports, dance, or club activities; 67% responded “yes,” and 33% responded “no.”

Mission statement themes. Participants were asked what themes were in the mission statements of their programs; 70% responded ”improving interpersonal relationships,”

70% responded “empowerment,” 67% responded “emphasis on family relationships,” 67% responded “making positive choices,” 57% responded “building self-esteem,” 33% responded “identity development,” 26% responded “spirituality or religious focus,” 7% responded “other,” 4% responded “evidence-based,” 4% responded “healing trauma,” and 2% responded “physical healing.”

Sexuality and Relationship Development

To explore the extent of attention paid to the development of sexuality, issues of sex, and relationship development issues in residential treatment facilities, participants were asked to respond to questions about access to birth control, screening for sexually transmitted infections, dating, discussions around sexual consent and activity, and sexual orientation of residents.

Sexual health. Participants were asked if the residents at their facility received birth control and information on using birth control; 85% responded “yes,” and 15% responded “no.”

Participants were asked if their residents were screened for STIs; 89% responded “yes,” and 11% responded “no.”

Participants were asked if consent and sexual decision making were discussed with residents at their facility; 96% responded “yes,” 2% responded “no,” and 2% did not answer the question.

Dating. Participants were asked if their residents were allowed to date individuals within the program; 83 responded “yes,” and 17% responded “no.” Participants were asked if their residents were allowed to date individuals outside of their program; 67% said “no,” and 33% responded “yes.”

Demographics. Participants were asked what percentage of their residents identified as homosexual; 17% responded “0%,” 9% responded “5%,” 7% responded “10%,” 7% responded

“15%,” 4% responded “3%,” 2% responded “33%,” 2% responded “30%,” 2% responded “23%,” 2% responded “unknown,” and 52% did not answer the question.

Participants were asked what percentage of their residents identified as bisexual; 13% responded “0%,” 11% responded “5%,” 4% responded “33%,” 4% responded “unknown,” 2% responded “12%,” 2% responded “4%,” and 63% of participants chose not to answer this question.

Participants were asked what percentage of their residents identified as heterosexual; 7% responded “100%,” 7% responded “90%,” 4% responded “80%,” 4% responded “85%,” 2% responded “66%,” 2% responded “94%,” 2% responded “33%,” 2% responded “95%,” 2% responded “unknown,” and 66% of participants chose not to answer this question.

Staff Issues and Training

To explore the extent of attention paid to the training and issues relating to staff in residential facilities, participants were asked to respond to questions about types of training received, restraints used on residents, supervision received, and staff demographics.

Training. Participants were asked what types of training they received from their residential facility; 96% responded “CPR/first aid training,” 93% responded “de-escalation training,” 89% responded “ethics and boundaries training,” 87% responded “mandated report training,” 87% responded “trauma-focused training,” 87% responded “cultural issues and diversity training,” 87% responded “medication training,” 80% responded “restraint training,” 74% responded “child/adolescent development training,” and 24% responded “other.”

Interactions with residents. Participants were asked if staff restrained residents at their facility; 80% responded “yes,” and 20% responded “no.” Participants were asked if staff members ate meals with residents at their facility; 98 responded “yes,” and 2% responded “no.”

Participants were asked if staff ate meals with residents, did they actively model healthy eating behaviors such as following suggested serving sizes; 87% responded “yes,” and 13% responded “no.”

Staff demographics. Participants were asked how many staff were employed at their facility; 7% responded “50,” 4% responded “30,” 4% responded “200,” 2% responded “8,” 2% responded “130,” 2% responded “300,” 2% responded “200,” 2% responded “65,” 2% responded “135,” 2% responded “100,” and 72% of participants chose not to answer this question.

Participants were asked what percentage of their staff were male; 11% responded “40%,” 9% responded “50%,” 4% responded “35%,” 4% responded “0%,” 2% responded “25%,” 2% responded “55%,” 2% responded “30%,” 2% responded “20%,” 2% responded “30 %” and 61% of participants chose not to answer this question.

Participants were asked what percentage of their staff were female; 11% responded “60%,” 9% responded “50%,” 4% responded “100%,” 4% responded “65%,” 4% responded “70%,” 2% responded “25%,” 2% responded “45%,” 2% responded “80%,” and 60% of participants chose not to answer this question.

Participants were asked what percentage of staff at their facility had attained a master’s degree or higher; 9% responded “10%,” 4% responded “40%,” 4% responded “30%,” 4% responded “15%,” 2% responded “35%,” 2% responded “33%,” 2% responded “80%,” 2% responded “0%,” 2% responded “unknown,” and 67% of participants chose not to answer this question.

Supervision. Participants were asked if the direct-care staff at their facilities received supervision; 100% responded “yes,” and 0% responded “no.” Participants were asked who provided supervision to direct-care staff; 57% responded “a senior direct care staff,”

24% responded “a masters-level clinician,” 9% responded “other,” 2% responded “a doctoral-level clinician,” 2% responded “bachelor’s level,” and 2% responded “an administrator.”

Interpersonal relationships. Participants were asked whether platonic friendships between residents were encouraged at their facility; 85% responded “yes,” 13% responded “no,” and 2% of participants chose not to answer this question.

Participants were asked if residents were encouraged to build friendships outside of the program; 70% responded “yes,” and 30% responded “no.”

Participants were asked if residents had contact with their families at their facility; 100% responded “yes,” and 0% responded “no.”

Participants were asked to identify the ways that contact with families was facilitated; 98% responded “phone calls,” 98% responded “family therapy,” 91% responded “unsupervised visits in the home or community,” 89% responded “supervised visits at the facility,” 39% responded “supervised visits in the home,” 9% responded “Skype,” 4% responded “other,” and 2% responded “letter writing,”

Participants were asked if relational growth was a treatment goal for residents at their facility; 98% responded “yes,” and 2% responded “no.”

Participants were asked how verbal conflicts were managed within their program; 98% responded “mediated conversation between individuals,” 74% responded “separation of individuals,” 48% responded “consequences or punishment,” 11% responded “other,” 2% responded “treatment team meeting,” and 2% responded “group processing.”

Participants were asked what percentage of their residents had experienced a history of sexual assault, abuse, or molestation; 9% responded “100%,” 4% responded “33%,” 4%

responded “40%,” 4% responded “75%,” 2% responded “55%,” 2% responded “60%,” 2% responded “30%,” 2% responded “90%,” and 2% responded “98%.”

Discussion

The results of this study were discussed, and interpretations regarding the proposed individual hypotheses were explored. Based on the results of this study, it was possible to discuss the services being offered to residents in adolescent residential facilities. It was also possible, based on the results of this study, to discuss the implications and possible factors for future research and the ability to meet the needs of adolescent females in this treatment environment.

Overall, the findings of the study were quite encouraging and with limited negative outcomes or areas of concern. The significant positive findings of the study included programs offering a wide range of individual and group therapy services, medication management services, academic services, access to exercise programs, a wide variety of staff training, supervision for staff, and life skills development programs.

The study found a few problematic issues, such as the use of punishment, lack of transitional programs, and the reported use of restraints on residents.

General Program Information

Based on participants’ responses to the types of services and therapeutic approaches offered in residential facilities, it is clear that, while a wide variety of services were being offered in residential facilities, there was little variability across programs. This may be a product of adolescent residential facilities treating a specific population. However, this lack of variability in services being offered may be leaving the needs of diverse populations in this treatment setting unmet or partially met.

Focus of residential facilities. Respondents from over three-quarters of adolescent residential facilities reported that their primary focus was on mental health treatment with less than one-quarter specializing in the dual diagnosis treatment of mental health and substance abuse. While substance-abuse-treatment-specific facilities were excluded from this study for the sake of operationalizing the definition of a residential facility, it was thought-provoking that so few facilities had a focus on dual diagnosis treatment, as this may be a significant barrier for those with a dual diagnosis to receiving effective treatment.

A substantial number of participants, nearly three-quarters, said that the top three areas of focus of their programs were improving interpersonal relationships, instituting individual behavior change, and stabilizing mental health issues. Significantly fewer programs, 28%, identified that improving academic achievement was a top-three focus of their facility. While adolescents entering residential facilities do tend to be struggling in academic settings, this can be a result of the combination of emotional dysregulation, anxiety, and school truancy. Therefore, this response from programs is likely a reflection of the understanding that addressing psychological and emotional issues first helps to simultaneously address issues related to academic struggles.

The issues that tended to lead adolescents to placement in residential facilities were overwhelmingly related to behavioral issues in various settings. Nearly 100% of respondents said that behavioral issues in the home were a driving factor for residential placement, 89% pointed to behavioral issues at school, and 76% stated that behavioral issues in the community were a factor for residential placement. Additionally, 63% noted that aggressive or violent behavior was often a reason for placement, another behavioral issue that can be included with those listed above.

Eighty-nine percent reported that a previous placement in a hospital psychiatric unit

contributed to residential placement, which highlights the high level of need and emotional dysregulation that many of these adolescents experience. Trauma also appears to be a significant factor in placement, as 80% reported physical or sexual abuse as a reason for placement, and 54% reported the removal from the family system by the Department of Children and Families or a similar agency.

Despite 80% of residents having experienced at least one incident of traumatic sexual or physical abuse, only 2% of participants wrote in that one of the primary foci of their facility was treating trauma. This might be the result of programs having an extensive list of areas that they address, with a focus on trauma not at the top. It is also likely that behaviors that are disruptive or aggressive are thought of and addressed first. While addressing underlying trauma certainly can change individual behaviors, it might not be the first problem that is identified with an individual.

Overall, it is most likely that the extremely low response rate of “treating trauma” is because the response was simply not provided as an option among the other responses. I do not believe that this is an accurate reflection of the focus of residential facilities, and believes that this number would have been significantly higher had she included it as an option for participants.

Interestingly, 59% of respondents stated that substance use or abuse issues contributed to residential placement, although only one-quarter of programs identified as dual diagnosis treatment facilities. This may speak to the experimental nature of adolescent drug use that has not crossed into the substance abuse category, and therefore, may not be appropriate for treatment in a dual diagnosis or substance abuse facility. Conversely, this may indicate that a resident does have a high need for substance abuse treatment and there are too few dual

diagnosis treatment centers, resulting in a placement at a residential facility that was easier for an individual or family to access.

Acting-out behaviors are the most likely to result in removal from the home and placement in a residential facility. This is an unsurprising finding, as it remains well documented that acting-out behaviors in adolescents often result in psychological or neurological struggles being identified more quickly than in adolescents who tend to internalize their issues (Davidson-Arad, Englechin-Segal, & Wozner, 2003).

Adolescents placed in residential facilities and therapeutic boarding schools have highly diverse backgrounds that often include acting-out behaviors, trauma, and family systems issues. Given that 26% of participants said that "other" reasons contributed to placement in their programs, it would also be interesting to further explore the additional reasons for placement that were not included in this study.

Resident demographics. The number of residents in each program ranged from 3 to 145 residents, with between 30 and 60 residents being the most common response (20%). Programs having between 15 and 20 residents were the second most common response at 18%. Only 2% of programs reported having fewer than 10 residents. However, since 43% of respondents chose not to answer this question, this is likely a poor representation of how many residents are actually in adolescent residential programs.

Additionally, it would be interesting and helpful to explore the staff to studio ratio in residential facilities, as residents tend to do better in treatment programs with increased individualized attention from staff and a lower staff to resident ratio.

There was a nearly even split between programs that were co-ed or gender-specific, with 54% being co-ed and 46% being gender-specific. Of these co-ed facilities, one-quarter said that

they currently had 12 males and 4 females, and one-quarter said that they had an even split of 50 males and 50 females. Interestingly, the other 50% of respondents indicated that they were co-ed facilities, but currently had 0 residents of one gender; 25% said that they currently had 125 males and 0 females, and 25% said that they had 0 males and 25 females. It is important to note that only 21% of total survey respondents chose to answer this question, and only 9% of total respondents answered the question in the format requested by myself (number of residents of each gender). Therefore, the number of males and females represented in co-ed residential facilities are likely highly skewed due to low or unusable response numbers.

It is also interesting to me that programs that identify that they are co-ed facilities would report having zero residents of one gender. While this is possible and does occur in smaller programs from time to time, these responses may also indicate confusion on the part of the respondents regarding the question being asked.

In terms of residents identifying as transgender within adolescent residential facilities, the most common response was that 0 residents identified as transgender (35%), 41% of programs said that they had between 1 and 3 residents identifying as transgender, only 2% of respondents said 9 or more residents identified as transgender, and 7% of respondents chose not to answer this question.

These numbers, of course, reflect the assumption that these residents have self-identified as transgender to those around them, leaving the possibility that these numbers are not an accurate reflection of transgender adolescents in treatment facilities. This is particularly true when the idea of gender existing on a spectrum is considered, as an individual does not need to identify as transgender to exist somewhere between the far ends of identifying as either fully male or female. Given that transgender individuals continue to be a highly stigmatized and often

violently targeted population, I do not believe that adolescents should be pressured or "outed" as identifying as transgender in treatment facilities; rather, residential facilities should be knowledgeable of and able to address the needs of this population. While the topic of addressing the unique needs of transgender adolescents in residential facilities is beyond the scope of this study, this is a population that needs continued research, support, and protection within mental health treatment and the field of psychology.

Two respondents stated that their residents were too young to understand or identify as transgender. While these respondents may have been trying to express that younger children may lack the language capacity to accurately express gender dysphoria or incongruent gender identity, it is also possible that these respondents were expressing the mistaken belief that younger children are unable to feel as though their gender does not match their sex assigned at birth. As the latter is an alarming and potentially dangerous belief for a mental health provider to hold, this demonstrates the continued need for improved research, education, and understanding of this population.

Ages of residents in facilities ranged from 4 to 21 years of age with almost 65% of programs providing treatment to ages that included 11 to 21. Only 24% of programs said that their facilities treated ages 4 to 10, and 35% of survey respondents chose not to answer this question. The average age span within programs was 7.6 years. The smallest age span reported was 6 years, and the largest was 15 years.

Residential facilities that include adolescents often include younger children or emerging adults in their programs. It is unclear from this study how these age differences were managed within different programs. As there are often enormous differences in development, maturity, and behavior across different age ranges, it would be an important aspect of program

development to determine the separate age groups within a program as well as determining if or how much contact various age groups might have with one another.

When asked about the racial representation of residents within their facilities, 100% of participants said that their program had Caucasian residents, and nearly 100% (96%) said that they had Black residents in their program. Interestingly, only about half of the programs had Asian, American Indian, or Alaskan Native residents, and only about one-quarter of programs had Hispanic residents (24%). A very small percentage of programs, 2% each, reported having Korean, East Indian, and mixed-race residents in their facilities. While the percentage of Korean, East Indian, and mixed-race residents appears staggeringly low, these responses were the result of survey participants writing in additional responses rather than a choice offered by myself on the survey. Had these options been presented as a choice to every respondent on the survey, it is likely that these numbers would be higher and more accurately reflect the inclusion of Korean, East Indian, and mixed-race residents in treatment facilities.

The differences in the representation of various ethnic groups in treatment are an interesting and relevant topic in the field of psychology. While the data collected indicate that Caucasian and Black residents were represented at nearly equal levels, and close to 100% in adolescent residential treatment programs, I believe that this representation in treatment was for significantly different reasons.

The disparities in recognition of mental health issues and the provision of mental health treatment in Black communities in the United States are well documented, as Black children and adolescents tend to have their acting-out behavior (e.g., truancy, drug use, violent behaviors, running away, property crimes) viewed as a problem that needs to be punished rather than a symptom of other problems that may include issues of racism, socioeconomic struggles, and

mental health issues that require treatment, rehabilitation, and change at a societal level. Black adolescents are often treated more punitively than their White counterparts, resulting in a significantly higher number of Black adolescents in juvenile detention centers. This is particularly true for Black adolescent males, who are represented at 5.4 times the rate of White adolescent males (U.S. Department of Justice, 2017) in juvenile detention centers. Thus, when Black males are placed in residential facilities, they often have a history that includes juvenile detention. While it was outside the scope of this study to examine and discuss the additional trauma often experienced by children and adolescents in juvenile detention centers, it is not difficult to imagine that the experiences of Black adolescent residents who are placed in residential facilities may vary significantly from others.

The mental health of White or Caucasian adolescents in the United States is often treated quite differently with acting-out behaviors being viewed as a symptom of a larger problem, often contributed to mental health or learning struggles in an academic environment. Thus, the treatment for the elimination of these behaviors in White adolescents often emphasizes mental health treatment or rehabilitation, with juvenile detention facilities being perceived as a "last resort." This is particularly true with Caucasian adolescent females, who are 3.4 times less likely to be placed in a juvenile justice facility than Black adolescent females, and 23 times less likely to be placed in a juvenile justice facility than Black adolescent males (U.S. Department of Justice, 2017). Thus, while Black and Caucasian adolescents may both be represented at nearly 100% in residential communities, the reasons and course of treatment behind this representation are typically quite different.

Approximately half of the survey respondents said that their programs had Asian (52%) and American Indian or Alaskan Native (50%) students, and about one-quarter (24%) of

programs had Hispanic students. Interestingly, Asian, American Indian or Alaskan Natives, and Hispanic adolescents are represented in significantly lower numbers than Black and Caucasian adolescents in residential treatment. These numbers may be a product of how mental health and mental illness are viewed within different cultures, as the stigma against seeking mental health treatment can be quite strong within families that do not view mental illness as valid or recognize that many symptoms require specialized treatment. This disparity in racial representation within residential facilities may also be a result of how mental health providers themselves view and address mental illness in various races. If a mental health provider is unable to recognize symptoms of mental illness or emotional distress in an adolescent of a particular race due to his or her own bias or lack of cultural awareness, that adolescent may not receive the level of care needed.

Additionally, this study did not distinguish between state-run and private residential treatment centers or therapeutic boarding schools; an important distinction to make when considering the financial implications behind these placements. Many private facilities require out-of-pocket payment for services, and many do not work with insurance companies. With costs that range from $5,000 to $20,000 per month for private facilities, a large portion of the population in need of services is barred from access and must seek alternative placements. Therefore, access (or lack of) to wealth is often a primary indicator of placement into specific adolescent residential facilities. Financial stability is likely an additional factor in what racial identities are represented in each program, as wealth disparity by race continues to be an issue in the United States.

Services provided. Nearly 100% of programs provided residents with individual therapy (98%), family therapy (96%), medication management (96%), and group therapy (93%). These

results were surprising at first, as I expected that 100% of programs would provide these services. However, it is possible and likely that programs that responded “no” provided residents with these services at an outside location. This is particularly likely for the 4% of programs that do not provide medication services within the program, as medication management can be highly costly to provide within a program, particularly a very small one. Given the nature of residential treatment centers, it would be of great concern if therapy services and medication management were not provided to residents at all.

Life skills training and behavior management were provided at 89% of programs, and 78% provided case management services within the program. Only about half of the treatment programs provided transitional living programs (54%), and less than 40% (37%) had a peer-counseling program for residents. While case management services are not being directly offered at every program, it is a certainty that direct-care staff and/or therapists in all programs are providing some level of case management services to their residents, as this is an organizational requirement within programs, particularly when a resident is moving on to the next stage of treatment or returning to his or her community. Similarly, although not every program explicitly lists behavior management as a service in their facility, it is expected that a combination of therapeutic services, structure, and other environmental factors lead to behavioral changes in their residents.

Only slightly more than half of programs are providing transitional living as part of treatment concerns, as individuals who receive mental health treatment tend to struggle when services are stepped down or removed entirely. Transitional programs serve as a gradual way to eliminate services that continue to provide the individual and their family with an environment that supports growing health and independence as well as the need for titrated services.

While fewer than 10% of programs reported that they provided animal therapy, a parent support program, trauma therapy, and “other” services, it is important to note that these were written in by respondents and may not accurately represent the rates that these services are being provided in residential treatment centers.

More than three-quarters (80%) of programs have schools on their premises, about one-quarter (26%) have students who attend public schools, and about 10% of programs have clients who attend an outside specialized or behavioral school. It is also common for staff members to attend school with their adolescent clients and for tutoring to be provided on the premises (about 50%). Given that academic success can dictate future success, as well as academic legal requirements in many states, it is unsurprising that residential facilities have such a significant focus on academic preparedness and services.

Individual therapy is often considered one of the cornerstones of successful residential treatment, and 98% of survey respondents said that their program provides individual therapy to their residents. Of the programs that provide therapy in their facilities, nearly all of them (91%) said that they had therapists who used cognitive behavioral therapy. These numbers declined significantly with other approaches to therapy, as only about half of programs utilized behavior therapy, integrative or holistic therapy, psychodynamic therapy, and Rogerian or person-centered therapy. Fewer than 10% of survey respondents reported that their programs used trauma-focused therapy, eye movement desensitization and reprocessing (EMDR) therapy, play therapy, and “other” therapy. It is important to note that trauma-focused therapy, EMDR, play therapy, and “other” therapy were therapeutic approaches that were written in by survey respondents, and may not be an accurate representation of the extent to which these services were offered in all programs. Additionally, any of the above approaches to individual therapy

can be understood and implemented in a trauma-informed way.

All programs either allowed access to, or required their residents to participate in, an exercise program. This is unsurprising given that exercise and physical movement have been linked with improved mental health and decreased symptoms of anxiety and depression.

Nearly 90% of respondents (89%) said that their program incorporated a life skills component into their curriculum. Over three-quarters of programs that involved a life skills component said that they included cleaning or housework, laundry, and time management /planning activities into their program. About three-quarters of programs that included life skills development had meal planning and meal preparation/cooking, and about half of the programs had their residents working on budgeting and grocery shopping. One-quarter of programs supported their residents in accessing public transportation. While it was encouraging that nearly 90% of programs actively focused on helping residents to develop life skills, I anticipated that a higher number of programs would emphasize budgeting, as this is an important skill that young adults often express they are lacking. Given that grocery shopping and accessing public transportation are life skills that require access to the local community, it is understandable that not all programs are designed to accommodate the development of these skills. The development of life skills is both a way to send adolescents back into their communities or to future placements with a concrete set of skills to utilize, as well as a way to foster improved self-esteem and a sense of autonomy and competence in navigating the world around them.

Behavior management techniques within facilities were varied and often included multiple behavior management techniques within one program. Over three-quarters of programs utilized natural consequences, and about 60% incorporated some type of level system. About one-quarter of programs used a token economy and behavior charts. Fewer than 10% of

programs utilized punishment as a behavior management technique. While it was encouraging that the number of programs using punishment was low, even a small percentage was of concern, as punishment has been firmly ruled out as an effective behavior management strategy within the field of psychology (Solomon, 1964).

I wanted to allow for the exploration of additional behavior management techniques used in programs and allowed survey respondents to write in "other" responses. Nearly one-quarter of respondents indicated that their programs used additional approaches to behavioral management and wrote in "other" responses. However, these responses seemed to indicate an overall confusion around the idea of consequences and punishment, with many respondents describing behavior management that fit into previously listed categories of behavior management.

There appears to be a movement away from more traditional behavior management approaches, such as using behavior charts and token economies to motivate a change in behavior. While these behavior-monitoring and reward systems have their uses in residential treatment, they are often criticized for failing to translate to social, academic, or occupational settings once treatment has been completed and it is encouraging that programs are integrating other behavior management techniques.

Mission Statement Themes

Mission statements are often used in treatment facilities as both a way to market the program to prospective families and other treatment providers seeking services, as well as a foundation for developing and guiding key components of their treatment.

Nearly three-quarters of programs stated that their mission statement included improving interpersonal relationships, empowerment, making positive choices, and an emphasis on family relationships. Approximately 60% of programs emphasized building self-esteem, and about

one-quarter included identity development. About one-quarter of programs included spirituality or a focus on religion in their mission statements. While this is not a cornerstone for most psychological treatment, it is likely that a religiously conservative portion of the population would seek out programs that align with their belief systems, particularly when choosing a placement for their child who is away from home. When respondents were given the opportunity to write in additional mission statement themes, they included evidence-based approaches, healing trauma, and healing the physical body. These numbers would likely have been higher if they had been included in the list of survey response options.

Sexuality and Relationship Development

It is clear from the data collected that the majority of programs are addressing the sexual health, wellbeing, and development of their residents. This is highly encouraging, as navigating the development of sexual identity, sexual expression, and consensual sexual contact with others is an important area of adolescent development that has historically been treated as taboo.

Sexual health. Nearly 90% of adolescent residents have access to birth control, information about the proper use of birth control, and are screened for STIs. Additionally, almost every program (96%) said that issues of consent and sexual decision-making were discussed with residents at their facility. Given that female-presenting individuals are most often on the receiving end of sexual violence, it is highly encouraging that this topic was being addressed in a wide variety of residential treatment facilities. While it was outside the scope of this study to identify how thoroughly or thoughtfully this topic was being approached with residents, it was clear that programs were at least including it in their programming. Ideally, all programs would offer these services to residents to encourage healthy sexual development. However, the current high rates indicate that sexual health was a priority in most programs.

Dating. The topic of dating among residents in an RTC is an interesting one, as residents largely lacked the freedoms that other adolescents might have who were not in a treatment facility. Most were unable to access traditional dating venues in the community such as a restaurant or coffee shop, and the rigid structure and clear rules of many facilities likely changed the dating dynamics significantly. For example, many treatment facilities have strict rules about physical touch among residents, an aspect of dating or being in a romantic relationship that many adolescents desire. Approximately 80% of programs allowed their residents to date one another within the program, and about 70% allow their residents to date an individual outside of the program. Many respondents clarified that dating while in treatment was discouraged, but not expressly forbidden, as it was nearly impossible to enforce. Additionally, many residents entered treatment while dating someone outside the treatment facility.

While there are obvious concerns around encouraging dating activities such as adolescents engaging in sex or sexual acts, it is the firm belief of mine that dating should not be discouraged or forbidden in residential facilities. During this period of development, adolescents must develop an understanding of what healthy romantic and sexual relationships look like. While they should be closely monitored for their own safety, they should also be allowed to develop and practice skills such as advocating for their needs and setting and holding boundaries within the context of a romantic relationship. Practicing these skills within an RTC also allows for them to receive feedback and guidance from trusted adults. If adolescents are unable to develop these skills in romantic relationships due to overly restrictive rules in a facility, they are highly likely to struggle to form healthy relationships once they leave the facility.

Demographics. The percentage of residents who identified as homosexual in residential facilities ranged from 0% to 33%, with 0% being the most common response (17%). The

percentage of residents who identified as bisexual ranged from 0% to 33%, with 0% being the most common response (13%). The percentage of residents who identified as heterosexual ranged from 33% to 100%, with 100% being the most common response.

These questions were clearly difficult for respondents to answer; as between 50 and 65% of survey respondents chose not to answer them. While collecting demographic information about sexual orientation from a secondary source is difficult, it is an important component to attempt to capture, as it can factor heavily into development and mental health struggles.

Staff Issues and Training

The data collected around staff issues and training in treatment facilities reflect that, while there are some clear areas of weakness, programs are oriented toward training, supervision, and developing interpersonal relationships with their residents.

Training. Programs placed a clear emphasis on staff training, as nearly 100% of programs provided CPR/first aid training and de-escalation training. De-escalation training is especially important, as these techniques can help to maintain the safety of both staff and residents, reduce the use of physical restraints, and avoid coercive interventions that increase distress and strain therapeutic relationships (Richmond et al., 2012).

Ethics and boundaries training, mandated report training, trauma-focused training, cultural issues, diversity training, and medication training were provided to about 90% of programs. Over three-quarters of programs were also provided with restraint training and child/adolescent development training. While it was beyond the scope of this study to examine the depth and breadth of training topics, it is a positive development that so many programs are providing a variety of training for their staff.

Interactions with residents. About 90% of programs said that staff members eat meals with residents and of those programs, nearly 100% actively work on modeling healthy eating behaviors. Eating meals together allows for staff to be able to closely monitor for eating-disordered behavior among residents and provides a communal experience that fosters relationship development.

The data collected show that 80% of programs physically restrain residents. While these numbers seem quite high, it is unclear the extent to which restraints were used in residential facilities in this study. For example, some programs instruct their staff that the physical restraint of residents should be used only when a resident is in immediate danger of hurting him or herself, staff, or another resident. While working in a small RTC, I had the experience of receiving yearly restraint training, but never came close to using a restraint during her two years of employment. In fact, her direct supervisor, who had been working at the facility for nearly a decade, had never used restraint and did not know of any other staff member who had. In this study, this program would have reported using restraints and being trained in restraints, but did not use them in practice. While the author ideally hopes that this is also the case with the other programs that reported using restraints, past research and anecdotes from colleagues working in other RTCs indicate that it is probably not.

Other programs utilize restraints much more frequently, and sometimes before physical aggression has actually occurred. In fact, restraints seem to be used at times before a resident is even significantly escalated. Given that research indicates that the use of restraints has been associated with re-traumatization, reduction in the therapeutic alliance, and physical injury to both staff and residents (Van Loan, Gage, & Cullen, 2015), it is of concern that this practice continues in RTCs.

While it is outside the scope of this study to thoroughly examine the practice and reasoning behind the continued use of restraints in RTCs, I believe there are several interacting factors that contribute. First, the field of psychology is not always particularly adept at changing quickly and implementing changes to established beliefs and protocols. This may be the case with the continued use of restraints despite data indicating they can be detrimental to clients.

Second, it is important to keep in mind that the staff who are most likely to restrain a resident are the direct-care staff. Direct-care staff traditionally have the least amount of education within an RTC, and may not understand why a client is behaving in a certain way and how to react appropriately. In some facilities, direct-care staff members are also significantly outnumbered by residents, resulting in them feeling unsafe at times, particularly when a resident becomes verbally aggressive, or it appears he or she may become physically aggressive.

A staff member lacking the education and understanding of what the client is experiencing, coupled with his or her own feelings of being "unsafe" in the moment, is probably more likely to use physical restraint. There may also be the belief among staff that showing physical dominance over residents will lead to improved behavior and fewer issues in the future. While this is certainly not the case, it becomes easier to understand why restraints continue to be routinely used. Overall, it is the hope of this researcher that programs are minimizing or completely eliminating the use of restraints.

Staff demographics. The number of staff members employed at residential facilities in this study ranged from 8 to 300, with the most common response being 50 (~10%). Interestingly, 72% of survey respondents chose not to answer this question. It seems unlikely that respondents would not have a general idea of how many people work at their facility, so it is unclear why participation in this question was so low. The percentage of male staff employed at residential

facilities ranged from 0% to 55%, with the most common response being 40%. The percentage of female staff ranged from 25% to 100%, with the majority of responses falling between 60 and 100%. Likely, the higher rates of women employed by residential treatment centers in this survey reflect the facilities that have only female residents.

Educational attainment by staff at residential facilities was varied, with the percentage of staff having attained a master's degree or higher ranging from 0% to 80%, with the most common response being 10%. The variability in responses is likely a reflection of the size and type of program. For example, some programs may utilize outside treatment providers for some or all of their therapy needs, resulting in fewer master's-level clinicians being employed by the facility.

Interpersonal relationships. The emphasis on interpersonal relationships in residential facilities is clearly reflected in the data, with programs emphasizing both peer and familial relationships. Relational growth and development were treatment goals for nearly 100% of programs and 85% of programs encouraged platonic friendships between residents. Residents at all programs had contact with their families, with nearly all having telephone calls, family therapy, supervised visits at the facility, or unsupervised visits in the home or community. The development and improvement of familial relationships were also supported through supervised visits in the home, Skype or other video calling, and letter writing.

Managing verbal conflicts within treatment facilities was also a primary focus with nearly 100% of programs using mediated conversation between individuals, three-quarters of programs separating individuals having conflict, and half of the programs implementing consequences or punishment to those involved. Additional verbal conflict management tactics included treatment team meetings and group processing.

Other Correlational Analysis

The remaining variables that were examined for correlational relationships included the likelihood that all-female programs (versus co-ed) would provide a higher number of female-related services, that facilities that have staff that hold a higher percentage of master's and doctoral degrees will provide a higher number of total services to their residents and provide more training for their staff.

First, no significant correlation was found between the likelihood that female-only programs (versus co-ed) would provide a higher number of female-related services. This means that the number of female-oriented services provided to residents did not increase when a program had only female residents. This could mean that programs are not identifying and providing their female residents with these services, or it could mean that programs are expanding these types of services to all residents, regardless of gender. With the continuing shift in the understanding of gender and gender identity, it would be most helpful in a treatment context to expand services across the board to be provided to all genders. Issues that have previously been largely conceptualized as "women's issues" must be expanded, discussed, and treated in a way that includes all genders and gender expressions.

Second, no significant correlation was found between the likelihood that facilities that hold a higher percentage of staff with master's or doctoral degrees provided a higher number of services to their residents. This means that the number of services provided to residents did not increase when a program had a higher percentage of staff with a master's or doctoral degree. While it appears that additional services are not being offered, this study only examined the number of services provided and did not explore the quality of those services. It is possible that programs with a higher percentage of staff with master's or doctoral degrees could implement a

higher quality of care using the additional education and experience that comes with an advanced degree.

Finally, no significant correlation was found between the likelihood that facilities that had a higher percentage of staff with a master's or doctoral degree provided more training for their staff. This means that the amount of training being offered to staff did not increase when a program had a higher percentage of staff with a master's or doctoral degree. This could reflect staff with master's or doctoral degrees needing outside training, as they cannot provide this training to themselves.

While additional training is not being offered by programs with a higher percentage of staff with advanced degrees, this study did not explore the quality of training that was provided. As with the types of services provided, it is possible that programs with a higher percentage of staff with master's or doctoral degrees could provide more in-depth, researched, and usable training to direct-care staff or others with less education who were employed at their facility.

While all three hypotheses lacked significant correlations, the data gathered from this survey have provided valuable information about the types of services that are being offered in adolescent residential treatment facilities.

Limitations of the Current Study

Considering the demographics of the participants involved in this study, a few factors stand out as possible limitations. A majority of programs, 52%, identified as being located in the western United States. This could be limiting because programs from other parts of the country are not as well represented, leaving room to question whether programs in other areas of the country have different demographics or are providing other services. Of the participants, 87% identified as heterosexual; this demographic variable may contribute to the data in ways that may

not be recognized without a more representative study.

Perhaps a major limitation of this study was that there might not have been enough participants to show a possible significant correlation between the likelihood that all-female programs (versus co-ed) would provide a higher number of female-related services, that facilities that have staff who hold a higher percentage of master's and doctoral degrees would provide a higher number of total services to their residents and provide more training for their staff. A higher number of participants would have given a clearer picture of the services being provided to adolescents across the country.

Another limitation of this study was the wording and design of parts of the survey. Many questions that required respondents to write in responses were skipped and greatly diminished the amount of data that could be gathered for these questions. This was also true for write-in responses that requested numbers or percentages. Additionally, respondents often seemed confused about the format that was needed for responses and would answer in ways that did not provide the information requested. Perhaps question formats that included Likert scales or multiple-choice responses would have increased respondent participation and decreased confusion around the format of responses.

Last, given what we know about the fluidity and spectrum of sexual orientation, I would have chosen to omit the demographics question gathering information on the sexual orientation of staff and residents, as it does not provide the information that it attempts to and narrowly defines a characteristic in an exclusionary way.

Directions for Future Research

The continued need for more research around residential treatment facilities for adolescents leaves room for many different directions for future research. One example is to

explore more about why different ethnicities and races access this level of treatment. This study only directly asked what races and ethnicities were represented in programs, but it would also be interesting to discover what symptoms, behaviors, socioeconomic factors, and life circumstances combine to result in the need for treatment for residents of different races and ethnicities. Future research that examines the factors behind treatment indicators could help to inform the treatment that these adolescents receive. This research could also be used to facilitate the training in cultural competency and empathy in staff members if they are better able to understand the likely traumas associated with different races.

Future research could also consider separating and examining state-funded, insurance-based, and private-pay treatment facilities to identify differences in the number and types of services provided in these settings. While a great increase in the cost of programs could reflect an increase in the standard of care, it may also simply be an indicator of a program's ability to market to families of high socioeconomic status. It would be interesting to understand better whether this increased expense is providing additional and more effective services to residents or simply improving the environment and location. Future research might examine the efficacy rates and reoccurrence of symptoms, academic issues, and acting-out behaviors as a correlate to the cost of a program. This study specifically wanted a broad picture of what services are being offered in adolescent residential facilities, but a more specific understanding of what differentiates these programs would be helpful to researchers, clinicians, and families who are often overwhelmed with making decisions about the placement of their adolescents.

It could also be informative to know what, if any, differences there are in male-only facilities. This study specifically focused on female-only and co-ed facilities, but an exploration of the services, therapies, and approaches offered in male-only treatment centers would provide

valuable information. This future research could provide the field of psychology with an excellent overview of how the treatment of adolescent males and females is being approached in this niche setting. This information could help to inform changes to program development or demonstrate that programs are operating similarly, regardless of gender orientation.

This study explored what types of training staff received in residential facilities, but it would be informative to know what staff members are receiving different forms of training. For example, do all staff attending training on trauma-informed treatment and care, or is this training provided only to therapists? Given that direct-care staff spend the most time with residents and have the majority of interactions with them, it would be important to understand how well trained they are on various psychological issues and approaches. This information would also provide data on areas of strengths and weaknesses in staff training that could inform changes and improvements to the training of staff in residential treatment facilities.

Overall Concluding Remarks

There is no doubt that the utilization of residential treatment facilities for adolescents continues to grow, with approximately 60,000 adolescents living in RTCs in the United States currently (Warner & Pottick, 2003). Given this ongoing use, psychologists and researchers must continue to explore and integrate their findings about the current offerings of residential facilities with the changing understanding of adolescent development and best practices to providing treatment. As residential treatment centers gained popularity as a new approach to working with emotionally disturbed children and adolescents in the 1950s and were particularly influenced by psychoanalytic theory (Leichtman, 2006), it is vital that the information and approaches to working with this population continue to be updated.

While no significant correlations were found between the likelihood that female-only

programs (versus co-ed) provided a higher number of female-related services, the likelihood that facilities that hold a higher percentage of staff with master's or doctoral degrees provided a higher number of services to their residents, or the likelihood that facilities that have a higher percentage of staff with a master's or doctoral degree provided more training for their staff, it is possible that these correlations would be present with a higher number of participants. This study was able to provide updated demographic information, use of therapeutic approaches, life skills development, relational development, and staff training information.

Overall, this study has contributed to the current body of knowledge on the services that are being provided in adolescent residential treatment centers (both all-female and co-ed). This population is in great need and has traditionally not responded to less intensive treatment approaches. Given the costs associated with residential treatment programs, the field of psychology must continue to work to ensure that this treatment is as beneficial as possible through ongoing research, program development, and program implementation by psychologists who are passionate about the care and future of adolescents struggling with mental health issues.

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Appendix: Survey

1. *What is your gender?*

_____ Male

_____ Female

_____Transgender

_____ Other (please specify): _____

2. *What is your race or ethnicity?* (Select all that apply)

_____ American Indian or Alaska Native

_____ Asian

_____ Black or African American

_____ Hispanic or Latino

_____ Native Hawaiian or Pacific Islander

_____ White or Caucasian

_____ Biracial

_____ Other (please specify): _____

3. *What is your sexual identity?*

_____ Heterosexual

_____ Gay

_____ Lesbian

_____ Bisexual

_____ Pansexual

_____ Questioning

_____ Other (please specify): _____

4. *What is your highest degree earned at the present time?*

_____ Associates

_____ Bachelors

_____ Master's

_____ PhD

_____ PsyD

_____ Other (please specify): _____

5. *Where in the United States is your facility located?*

_____ Midwest

_____ Northeast

_____ South

_____ West

6. *This residential treatment center is primarily focused on?* (Choose one)

_____ Mental Health Treatment

_____ Substance Use Treatment

_____ Dual Diagnosis Treatment

7. *How many residents are currently in your program?*

_____

8. *Is this facility gender-specific or co-ed?*

_____ Gender-specific

_____ Co-ed

9. *If your program is co-ed, how many residents of each gender?*

_____

10. *How many residents identify as transgender?*

_____

11. *Which of the following are identified by residents and/or their families as primary reasons for seeking residential treatment?* (Please choose all that apply)

_____ Behavioral issues at school

_____ Behavioral issues at home

_____ Behavioral issues in the community

_____ Previous placement in a hospital psychiatric unit

_____ Previous placement in juvenile detention

_____ Substance use/abuse issues

_____ Removal from the family system by the Department of Children and Families

_____ Aggressive or violent behavior

_____ Sexual or physical abuse

_____ None of the above

Other: Please specify: _____

12. *What age range does your facility treat?*

_____

13. *What are the top 3 focuses of your treatment program?* (Choose 3)

_____ Individual behavior change

_____ Stabilization of mental health issues

_____ Improved interpersonal relationships

_____ Reunification with family system

_____ Improved academic achievement

_____ Substance use treatment

Other: Please specify _____

14. *What services does your program provide?* (Please choose all that apply)

_____ Behavior management

_____ Life skills training

_____ Transitional living program

_____ Medication management

_____ Individual therapy

_____ Family therapy

_____ Group therapy

_____ Peer counseling

_____ Case management services

_____ Other: Please specify _____

15. *Please indicate which of the following academic services are provided by your facility?* (Please choose all that apply)

_____ School on the premises

_____ Tutoring on the premises

_____ Staff member attends school with client

_____ Clients attend public school

_____ Clients attend an outside specialized behavior school

_____ Clients do not attend school

_____ No academic services offered by this facility

_____ Other: Please specify _____

16. *If individual therapy is offered at your facility, which of the following approaches are represented?* (Please choose all that apply)

_____ Psychodynamic therapy

_____ Cognitive behavioral therapy

_____ Rogerian or person-centered therapy

_____ Behavior therapy

_____ Integrative or holistic therapy

_____ Dialectical Behavior Therapy

_____ Other: Please specify _____

17. *Do residents participate in an exercise program?*

_____ Yes, if they choose to

_____ Yes, it is mandatory

_____ No

18. *Does your program include life skills development?*

_____ Yes

_____ No

19. *If your program includes life skills development, please indicate which of the following are addressed.* (Please choose all that apply)

_____ Meal planning
_____ Budgeting
_____ Grocery shopping
_____ Meal preparation/cooking
_____ Cleaning/housework
_____ Laundry
_____ Accessing public transportation
_____ Time management/Planning

20. *Does your mission statement include any of the following themes? Please choose all that apply*.

_____ Building self-esteem
_____ Improving interpersonal relationships
_____ Emphasis on family relationships
_____ Empowerment
_____ Making positive choices
_____ Spirituality or religious focus
_____ Identity development
_____ Other: Please specify _____

21. *What behavior management techniques are used at your facility?* (Please choose all that apply)

_____ Token economy
_____ Natural consequences
_____ Level system
_____ Behavior charts
_____ Punishment

_____ Other: Please specify _____

22. *Which of the following races do **residents** represent at your facility?* (Please choose all that apply)

_____ American Indian or Alaska native

_____ Asian

_____ Black or African American

_____ Native Hawaiian or other Pacific Islander

_____ Caucasian

_____ Other: Please specify _____

23. *Does your facility have a transitional living program?*

_____ Yes

_____ No

24. *Does your program have a dress code for residents?*

_____ Yes

_____ No

25. *Are residents allowed to participate in activities outside of the facility such as sports, dance, or club activities?*

_____ Yes

_____ No

26. *Are the residents at your facility able to receive birth control and information on using birth control?*

_____ Yes, at our facility

_____ Yes, through an outside facility (primary care provider, clinic, etc.)

_____ No

27. *Are residents screened for sexually transmitted infections (STIs) (either through your facility or through outside health providers?)*

_____ Yes, all are screened

_____ Yes, but only if requested

_____ No

28. *Are residents allowed to date other residents **within** the program?*

_____ Yes

_____ No

_____ Other: Please specify _____

29. *Are residents allowed to date individuals **outside** of the program?*

_____ Yes

_____ No

_____ Other: Please specify _____

30. *Are consent and sexual decision making discussed with residents at your facility?*

_____ Yes, staff actively discuss this topic with residents

_____ Yes, but only if the topic is introduced by a resident

_____ No

31. *What percentage of your residents identify as homosexual?*

_____

32. *What percentage of your residents identify as bisexual?*

_____

33. *What percentage of your residents identify as heterosexual?*

_____

34. *Which of the following best describes the approach of your program to discussing sexual activity?* (Please choose one)

_____ Abstinence

_____ Safe sex/harm reduction

_____ Sexual activity is not addressed

35. *Which of the following types of training has your staff received?* (Please choose all that apply)

_____ De-escalation training

_____ Restraint training

_____ Mandated reporting training

_____ Child/adolescent development training

_____ Trauma-focused training

_____ Cultural issues and diversity training

_____ Ethics and boundaries training

_____ CPR/First aid training

_____ Medication training

_____ Other: Please specify _____

36. *Do your staff restrain residents?*

_____ Yes

_____ No, but other personnel at the facility do (security guards, etc.)

_____ No, restraints are not used at this facility

37. *Do staff eat meals with residents?*

_____ Yes

_____ No

38. *If staff do eat meals with residents, are staff actively modeling healthy eating behaviors such as eating balanced servings of each food group?*

_____ Yes

_____ No

_____ N/A

39. *How many staff are employed at your facility?*

_____

40. *What percentage of the staff are male?*

_____

41. *What percentage of the staff are female?*

_____

42. *Do direct-care staff receive supervision?*

_____ Yes

_____ No

43. *If yes, who provides supervision to direct-care staff?*

_____ A senior direct-care staff

_____ A master's-level clinician

_____ A doctoral-level clinician

_____ Other: Please specify _____

44. *What percentage of your staff have obtained a masters degree of higher?*

_____

45. *Are platonic friendships between residents encouraged?*

_____ Yes

_____ No

46. *Are residents encouraged to build friendships outside of the program?*

_____ Yes

_____ No

47. *Do residents have contact with their families?*

_____ Yes

_____ Yes, unless contact is not clinically appropriate

_____ No

48. *If residents have contact with their families, please identify the ways this is facilitated.* (Please choose all that apply)

_____ Phonecalls

_____ Family therapy

_____ Supervised visits at the facility

_____ Supervised visits in the home or community

_____ Unsupervised visits in the home or community

_____ Other: Please specify _____

49. *Is relational growth a treatment goal for residents?*

_____ Yes

_____ No

50. *How are verbal conflicts between residents managed within your program? Please choose all that apply.*

_____ Separation of individuals

_____ Mediated conversation between individuals

_____ Consequences or punishment

51. *To your knowledge, what percentage of residents has experienced a history of sexual assault, abuse, or molestation?*

_____

Table 1

Participant Demographics

	n	*%*
Gender		
Male	15	33
Female	31	67
Transgender	0	0
Ethnicity		
Asian	0	0
Black or African American	0	0
Hispanic or Latino	0	0
Native Hawaiian or Pacific Islander	0	0
White or Caucasian	44	96
Biracial	2	4
Sexual identity		
Heterosexual	40	91
Gay	1	2
Lesbian	3	7
Queer	0	0
Bisexual	0	0
Pansexual	0	0
Highest degree earned at present		
Bachelor's	4	9
Master's	34	76
PhD or PsyD	7	15
Residential program location		
USA (Midwest)	8	17
USA (Northeast)	9	20
USA (South)	4	8
USA (West)	24	53

Note. (N = 46)

Table 2

Survey Questions

Topics	Questions
Demographic and General Program Questions	1. What is your gender? 2. What is your race or ethnicity? 3. What is your sexual identity? 4. What is your highest degree earned at the present time? 5. Where in the United States is your facility located? 6. This residential treatment facility is primarily focused on: mental health treatment, substance abuse treatment, or dual diagnosis treatment. 7. How many residents are currently in your program? 8. Is this facility gender-specific or co-ed? 9. If your facility is co-ed, how many residents of each gender? 10. How many residents identify as transgender? 11. Which of the following are identified by residents or their families as primary reasons for seeking residential treatment? 12. What age ranges does your facility treat? 13. What are the top three foci of your treatment program? 14. What services does your program provide? 15. Please indicate which of the following academic services are provided by your facility. 16. If individual therapy is offered at your facility, which of the following approaches are represented. 17. Do residents participate in an exercise program? 18. Does your program include a life skills component? 19. If your program includes life skills development, please indicate which of the following are addressed. 20. Does your mission statement include any of the following themes? 21. What behavior management techniques are used in your facility? 22. Which of the following races do residents represent in your facility? 23. Does your facility have a transitional living program? 24. Does your program have a dress code for residents? 25. Are residents allowed to participate in activities outside of the facility such as sports, dance, or club activities?

Topics	Questions
Sexuality and Relationship Development Questions	26. Are the residents at your facility able to receive birth control and information on using birth control?
	27. Are residents screened for sexually transmitted infections, either within your facility or by an outside healthcare provider?
	28. Are residents allowed to date individuals *within* the program?
	29. Are residents allowed to date individuals *outside* of the program?
	30. Are consent and sexual decision making discussed with residents at your facility?
	31. What percentage of your residents identify as homosexual?
	32. What percentage of your residents identify as bisexual?
	33. What percentage of your residents identify as heterosexual?
	34. Which of the following best describes the approach of your program to discussing sexual activity?
Staff Issues and Training Questions	35. Which of the following types of training has your staff received?
	36. Does staff restrain residents?
	37. Do staff eat meals with residents?
	38. If staff do eat meals with residents, are staff actively modeling healthy eating behaviors such as following suggested serving sizes?
	39. How many staff are employed at your facility?
	40. What percentage of the staff are male?
	41. What percentage of the staff are female?
	42. What percentage of your staff have attained a master's degree or higher?
	43. Do direct-care staff receive supervision?
	44. If yes, who provides supervision to direct-care staff?
Interpersonal Relationships Questions	45. Are platonic friendships between residents encouraged?
	46. Are residents encouraged to build friendships outside of the program?
	47. Do residents have contact with their families?
	48. If residents have contact with their families, please identify the ways this is facilitated:
	49. Is relational growth a treatment goal for residents?
	50. How are verbal conflicts managed within your program?
	51. To your knowledge, what percentage of your residents have experienced a history of sexual assault, abuse, or molestation?

Note. Please refer to the appendix for a more comprehensive format of this survey.