2019

Therapist Attachment and Meaning-Making in Adolescent Residential Treatment

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Therapist Attachment and Meaning-Making in Adolescent Residential Treatment

by

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DISSERTATION

Submitted in partial fulfillment for the degree of
Doctor of Psychology in the Department of Clinical Psychology
at Antioch University New England, 2019

Keene, New Hampshire

ANTIOCH UNIVERSITY
NEW ENGLAND

Department of Clinical Psychology
DISSERTATION COMMITTEE PAGE

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THERAPIST ATTACHMENT AND MEANING-MAKING IN ADOLESCENT RESIDENTIAL TREATMENT

presented on October 4, 2019

by

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Acknowledgments

I would like to thank my Dissertation Chair and mentor, Dr. Martha Straus. Thank you for introducing me to the wonderful world of attachment theory—you helped me find where I belong in the world of psychotherapy. Thank you for helping me to experience, firsthand, the power of being seen, heard, and most importantly, felt. Thank you for your unconditional support, guidance, and love. And thank you for always believing in me, even when I did not believe in myself. I am proud to be the clinician I am today and that is largely because of you.

I would also like to thank my Dissertation Committee Members, Dr. Gina Pasquale and Dr. Cara Bonuso. Thank you for your time, your feedback, your unwavering support, and most importantly, thank you for being a part of this journey with me.

This dissertation is dedicated to all of my teens: past, present, and future. Thank you for your strength, your resilience, and for your fight; thank you for your honesty, your curiosity, your bravery, and for your inspiration; and thank you, most importantly, for taking a chance with me as your clinician. I have learned just as much about the healing nature of authentic and meaningful connections with others from you as I can only hope you have learned from me. And for that, I am eternally grateful.

Abstract

This qualitative study explores therapist views of the therapeutic relationship in adolescent residential treatment from an attachment perspective. The therapeutic relationship is a strong predictor of outcomes in adult psychotherapy and a significant body of research has relied on the attachment literature to understand its importance. Research yields comparable results when examining the significance of the therapeutic relationship with children and adolescents; however, there is virtually no literature exploring it from the attachment lens. This is particularly notable for children and adolescents in residential treatment. As treatment intensity increases from outpatient to inpatient to residential, challenges and opportunities within the therapeutic relationship increase, too: therapists form uniquely intense and intimate connections with children and adolescents they may see every day. This study employed constructivist grounded theory data analysis of semi-structured interviews with residential therapists exploring their views of the role of attachment in the therapeutic relationship with their adolescent clients. Key findings include role differences in therapists in adolescent residential treatment; the importance of affect management, attunement, and self-awareness within the therapeutic relationship in adolescent residential treatment; the healing nature of relationship, connection, and feelings of safety with adolescents in residential treatment; and the concept of attachment as fundamental in adolescent residential treatment. Implications for practice and training, limitations, and suggestions for future inquiry are also discussed.

Keywords: attachment theory, therapeutic relationship, psychotherapy, adolescent residential treatment, grounded theory, constructivist grounded theory, complex trauma

Therapist Attachment and Meaning-Making in Adolescent Residential Treatment

Literature Review

This qualitative study explored therapist views of the role of attachment in the therapeutic relationship with adolescents in residential treatment. In these placements, therapists typically have intense and frequent contact with adolescents who have previously endured unsafe and unpredictable relationships with adults. Indeed, the extended connection with a therapist in more intensive care is often the first stable and consistent relationship an adolescent may have ever had. Despite the fact that child and adolescent therapy may, for all intents and purposes, function as the safe haven and secure base common to all attachment relationships, research on child and adolescent treatment has been very slow to think about the client–therapist connection as an attachment relationship.

In contrast to adult research exploring attachment in psychotherapy in great depth (e.g., Wallin, 2007), and the therapists' attachment style in treatment (e.g., Levy, Ellison, Scott, & Bernecker, 2011), it is still widely held that for children and adolescents the attachment relationship need only develop with caregivers; therapists might even be overstepping to think of the therapeutic relationship as an attachment. Consequently, therapists who experience and recognize attachment bonds with their young clients have little guidance on either how typical or how useful this might be for enhancing therapeutic outcomes.

It would be useful for therapists working with children and adolescent clients to have more information about how the role of attachment in psychotherapy may impact the therapeutic process. The lack of research is particularly notable in adolescent residential treatment where therapists are functioning, to some extent, as primary caregivers. This qualitative study sought to understand therapists' meaning-making of their relationships with youth in residential treatment.

Problem Identification

Therapeutic Relationship and Treatment Outcomes in Psychotherapy Across the Lifespan

The therapeutic relationship (i.e., the relationship between clients and their therapists) is generally defined as "an emotional connection (e.g., affective attachment, affective bond, social support) and/or a cognitive connection in terms of agreement on the tasks and goals of therapy" (Harder, Knorth, & Kalverboer, 2013, p. 305). The therapeutic relationship is a strong predictor of outcome in adult treatment (Byers & Lutz, 2015; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Norcross, 2011) and has invariably been shown to be a reliable predictor of treatment outcome across a range of presenting problems, theoretical orientations, and treatment approaches in adults (Byers & Lutz, 2015; Lambert & Barley, 2001; Smith & Glass, 1977).

Research examining the therapeutic relationship and treatment outcome in child and adolescent psychotherapy has yielded similar results (Byers & Lutz, 2015; Karver et al., 2006; Shirk & Karver, 2003; Shirk et al., 2011). The therapeutic relationship with youth has further proven significant to therapy outcomes across multiple settings, including outpatient clinics and community mental health centers, psychiatric hospitals and/or psychiatric inpatient units, and residential treatment settings (Byers & Lutz, 2015). Although the client–therapist relationship plays a chief function in effective psychotherapy across ages and settings, our understanding of its particular role with youth in residential treatment is limited. A deeper consideration of the therapeutic relationship in alternative settings where direct care staff and therapists function as primary caregivers would contribute to improving overall treatment outcomes for some of the most at-risk youth (Byers & Lutz, 2015).

Complex Trauma and the Therapeutic Relationship in Adolescent Residential Treatment

Adolescents in residential treatment are more likely to have histories of

complex/developmental trauma and display higher rates of "impairment across a range of domains including academic problems, behavior problems, attachment problems, runaway behavior, substance abuse, suicidal ideation, self-injury, and criminal behavior" (Hodgen, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013, p. 679). They almost invariably enter residential treatment with a long legacy of dangerous and disappointing relationships with adults.

van der Kolk (2005) defines complex/developmental trauma as "the experience of multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature and early-life onset" (p. 402). These exposures frequently occur within the youth's caregiving or attachment system and include all forms of child maltreatment, including sexual abuse, physical abuse, psychological abuse, and neglect (van der Kolk, 2005). Blaustein and Kinniburgh (2010) note differences among youth who have endured isolated, acute, and non-interpersonal traumas, versus those who have contended with the cascading effects of the more chronic, sequential, and interpersonal complex/developmental trauma that is likely to interfere with emotional, intrapersonal, interpersonal, and cognitive development (Blaustein & Kinniburgh, 2010). The vast majority of youth in residential treatment have endured complex/developmental trauma.

The limited body of research that has explored the importance of the therapeutic relationship in out-of-home settings suggests its importance as "one of the most important nonspecific predictors of treatment success in both [youth] outpatient psychotherapy and residential treatment" (Zegers, van IJzendoorn, & Janssens, 2006, p. 325). In addition, a strong therapeutic relationship has been viewed as fundamental to positive treatment outcomes with complexly traumatized adolescents (Ormhaug, Shirk, &Wentzel-Larson, 2015). The therapeutic relationship may be particularly important for healing experiences of complex/developmental

trauma that invariably have a deleterious impact on internal working models about the self, others, and the world. More specifically, complex/developmental trauma alters internal working models about one's own lovability and others' dependability and trustworthiness—thus making the formation of a therapeutic relationship especially challenging (Ormhaug et al., 2015).

Relationship Between Adolescents in Residential Treatment and Direct Care Staff

Though research examining therapeutic relationships in adolescent residential treatment is limited (Holmqvist, Hill, & Lang, 2007), the relationship between residential youth and direct care staff has been studied in recent years. Direct care staff include staff assigned to perform direct responsibilities related to activities of daily living, pro-social behavior, and crisis intervention for youth in residential treatment settings. Direct care staff do not include therapists. For example, Knorth, Harder, Huyghen, Kalverboer, & Zandberg (2010) argue that direct care staff characterize the most essential and significant residential treatment team members because they interact with the youth for more hours in the day than anyone else. Knorth et al. further suggest that direct care staff are, de facto, the primary caregivers for youth in residential treatment. Therefore, the relationship between direct care staff and youth is considered a crucial element in successful residential treatment (Knorth et al., 2010).

In another related exploration, Florsheim, Shotorbani, Guest-Warnick, Barratt, and Hwang (2000) examined the role of the therapeutic relationship between direct care staff and juvenile delinquent males in community-based residential programs. Results revealed an association between positive relationships measured after three months in treatment with higher therapeutic gains and lower rates of recidivism. However, a positive therapeutic relationship measured early in treatment was correlated with negative outcomes, including higher rates of internalizing and externalizing behaviors and higher rates of recidivism (Florsheim et al., 2000).

This finding indicates that a positive therapeutic relationship measured early in treatment was not necessarily associated with behavioral change. The data do support the supposition that the gradual development of the relationship between direct care staff and juvenile delinquent males appears to hold more weight for obtaining positive outcomes than the relationship soon after admission (Florsheim et al., 2000). It is interesting to note that for these youth—as perhaps for us all—the impact of a supportive relationship might evolve over time, gradually changing how they feel and behave.

In a similar vein, Manso, Rauktis, and Boyd (2008) conducted a study utilizing qualitative methods to explore how youth in residential treatment view their relationships with direct care staff. Results suggested that the youths' views of the direct care staff are determined by the qualities and behaviors of the direct care staff as well as positive feelings about the direct care staff. Qualities of direct care staff identified by the youth included: (a) being helpful, responsible, and mature; (b) having good judgment and self-awareness; and (c) being trustworthy, caring, and genuine. Behaviors of direct care staff recognized by the youth included: (a) providing accurate feedback to youth, (b) listening and attending to their experience, and (c) establishing expectations and demonstrating commitment to the youth. Notably, youth understood that the direct care staff were responsible for maintaining the quality of the relationship, including the reparation of ruptures (Manso et al., 2008). These studies suggest that residential youth experience positive relationships with direct care staff as salient to improvements in their feelings and behavior.

Another study, also conducted on direct care staff, explores more specifically cognitive and emotional elements contributing to the quality of this relationship with juvenile delinquent males. In this inquiry, Holmqvist and colleagues (2007) showed that, at least for these boys, the

cognitive connection (i.e., agreement on the tasks and goals of treatment) aspect of the relationship was more related to positive treatment outcome than the emotional connection (i.e., affective bond; Holmqvist et al., 2007). These results suggest that it may be particularly therapeutic for direct care staff to be clear and consistent about expectations. It is interesting to note that for adults in this support role, the correlation between their experience of emotional support and treatment outcome is not as strong as for the youth.

The relationship between teachers and adolescents in residential treatment has also been the subject of investigation. For example, Harder and colleagues (2013) examined the quality of relationships and the positive and negative components between adolescents and both direct care staff and teachers in a secure residential treatment setting. The results revealed that adolescents, direct care staff, and teachers all experience a limited emotional connection in their relationship two months post adolescents' admission to the secure residential treatment setting (Harder, Knorth, & Kalverboer, 2013). In addition, adolescents and direct care staff typically recognize their relationship as "more secure and affective" than that between adolescents and teachers (Harder et al., p. 310). Overall, results showed that, even in the absence of a strong emotional bond, these traumatized adolescents still relied on direct care staff and teachers as a predictable and reliable secure base for their improved functioning.

As in the Holmqvist et al. (2007) research, Harder et al.'s (2013) findings suggest that positive treatment outcomes for juvenile delinquent males in residential treatment may rely more on clear, consistent understanding between direct care staff and youth than deep emotional ties. In light of the roles and functions of direct care staff and teachers, these data offer a window into the cognitive and instrumental nature of their relationships with adolescents.

Youth come to residential treatment settings with their own attachment histories that will

also have a predictive impact on the relationships they will have there. For example, in one study, Zegers, Schuengel, IJzendoorn, and Janssens (2006) conducted a mixed methods exploration of the association between youth attachment security and their relationships with direct care staff. Findings revealed, perhaps not surprisingly, that adolescents in residential treatment with more secure attachments more regularly utilized direct care staff as a secure base and less regularly evaded such contact in comparison to adolescents with less secure attachments. Notably, too, more securely attached adolescents were also more likely to find a secure base in those direct care staff who, similarly, had more secure attachment styles (Zegers et al., 2006).

A follow-up study conducted by Zegers (2007) further revealed that, irrespective of their attachment histories, adolescents in residential treatment who experienced high emotional and social support from direct care staff exhibited a decrease in acts of delinquency while in treatment; by contrast, adolescents who experienced low emotional and social support exhibited an increase in acts of delinquency (Zegers, 2007). Taken together, these results identified both historical and process factors associated with the quality of the relationship between adolescents and direct care staff.

Attachment Theory as a Conceptual Framework

Attachment theory, originated by John Bowlby and Mary Ainsworth, began as the study of bonding experience between infants and their primary caretakers (Janzen, Fitzpatrick, Drapeau, & Blake, 2010). Specifically, Bowlby (1982) believed that infants' proximity-seeking strategies with primary caregivers are instinctive responses for physiological regulation. Ainsworth et al. (1978) extended the theory to suggest that children foster attachment relationships as a way to develop a safe haven from distress and a secure base from which to

explore the world. The caregiver's ability to respond during periods of distress is viewed as a chief contributor to particular differences in the formation and functioning of the attachment-system (Fletcher & Overall, 2010; Janzen et al., 2010).

In a secure attachment relationship, caregivers effectively read and respond to an infant's behavioral cues enough of the time to promote the integration of these strategies into the infant's behavioral repertoire over the first few years of life (Calkins & Hill, 2007). For example, when an infant experiences minor or moderate distress and the caregiver effectively responds to the distress, the infant gradually internalizes the response and is more likely to utilize the strategy without the caregiver's support (Calkins & Hill, 2007)—or when the distress is greater, to be effective in seeking comfort from others. Depending on the caregiver's responsiveness, different patterns of attachment security and insecurity develop; over the course of childhood and adolescence, these experiences become internalized models of what to expect in relationships. A child's emerging sense of whether she is loveable and worthy of love is originally based in a caregiver's responsiveness to her; the internal working models (IWMs) of self and relationship that she develops will serve as a prophesy and guide for what she will find in later close relationships in adolescence and adulthood (Fletcher & Overall, 2010; Janzen et al., 2010).

More recent conceptions of adult attachment security designate an individual's degree of "comfort and confidence in close relationships on a continuum" determined, at least in part, by early experiences of caregiver availability in times of distress (Janzen et al., 2010, p. 364). This continuum describes the degree to which someone is secure, anxious, avoidant, or disorganized through examining how she currently navigates intimacy, rejection, interpersonal distance, and autonomy in primary relationships (Janzen et al., 2010).

Early experiences are predictive but not solely determinative of an attachment style; positive and negative relationships and events can increase or decrease felt security, moving us along the continuum over time. Over the life course, attachment relationships also form with individuals other than primary caregivers, including friends, teachers, romantic partners—and therapists (Buist, Dekovic, Meeus, & van Aken, 2004; Hamre & Pianta, 2001; Schuengel & van IJzendoorn, 2001). For youth who have endured significant early adversity, it is difficult, but not impossible, to increase attachment security through relationships that are reliable and responsive—including the therapeutic relationship.

Therapeutic Relationship from the Perspective of Attachment Theory

Bowlby further conceptualized attachment theory as a model of psychotherapy (Mikulincer et al., 2013) in which he suggested that the therapist could also become an attachment figure for the client (Levy, Ellison, Scott, & Bernecker, 2011; Mallinckrodt, Gantt, & Coble, 1995; Mikulincer et al., 2013). In the adult psychotherapy literature, significant scholarship supports an attachment framework for understanding the therapeutic relationship (e.g., Mikulincer et al., 2013; Wallin, 2007). Though there is not a comparable body of research in child and adolescent psychotherapy, this literature illuminates several ways in which all therapeutic relationships may be understood through an attachment lens.

For example, as potential attachment figures, therapists function as "targets of proximity maintenance," imparting a "physical and emotional safe haven," and a "secure base from which the client can explore and learn about the world" (Mikulincer et al., 2013, p. 607). Through the therapy process, the client re-experiences attachment patterns and reenacts with the therapist aspects of the often deficient and distressing relationships they have had in the past (Mikulincer et al., 2013). The therapist who responds differently than an IWM might predict may be

providing a corrective relational experience that can move a youth toward greater felt security.

When client attachment patterns are enacted in the therapeutic relationship, the therapist experiences the client's IWM firsthand. For example, an anxious client, vigilant to rejection and disappointment, might be quite upset when the therapist is late or has to reschedule for a different day. Through exploration of the client–therapist relationship and the client's relationships beyond therapy, in real time, opportunities to challenge and modify IWMs arise (Mallinckrodt et al., 1995).

As the client experiences the therapist as an effective caregiver—someone who is empathic, emotionally available, and offers a level of protection and security (i.e., one who provides a safe haven and secure base)—the client can form an increasingly secure bond with the therapist, developing what has been called "earned security" (Roisman, Padron, Sroufe, & Egeland, 2002). In other words, attachment security can be established even when it was not available earlier in a youth's life (Mallinckrodt et al., 1995; Mikulincer et al., 2013). Thus, client–therapist specific attachment experiences may impact the therapeutic process as well as subsequent relationships the client will have as a result of a more secure IWM (Sauer, Anderson, Gormley, Richmond, & Preacco, 2010).

In the past ten years, much research has been conducted with adults to assess and confirm the validity of Bowlby's model for psychotherapy when considering the applicability of the attachment construct to the client–therapist relationship (Mikulincer et al., 2013; Wallin, 2007). Given the fact that these therapy-specific explorations mirror more general studies on attachment over the life, there is sufficient reason to believe that the therapeutic relationship with youth can also readily be conceptualized as an attachment relationship.

Indeed, the dearth of comparable research on younger clients in treatment raises

significant questions about why this is so. One likely explanation suggests trepidation among therapists about challenging or threatening the sacrosanct primary bond a child has with a parent by presuming to foster attachment in their younger clients. After all, the therapy relationship is designed to have a termination date; this fact distinguishes it in some ways from other intimate connections. However, there is a large and growing body of research demonstrating that older children and adolescents benefit from multiple attachments in varied contexts (e.g., Buist et al., 2004; Hamre & Pianta, 2001; Schuengel & van IJzendoorn, 2001). It truly is notable that research examining the therapeutic relationship from an attachment perspective in youth treatment is so hard to find.

Studying attachment in therapy with adolescents in residential treatment is, perhaps, a careful way to begin: in most cases, they have endured significant adversity with their early primary caregivers; staff in these settings function “en loco parentis”—they are the caregiving adults with whom the youth is living for an extended period of time. Preliminary findings on the important and essential connection with direct care staff and teachers detailed in this chapter, provide further evidence that a youth in residential treatment is, indeed, having new and valuable attachment experiences.

The present study expands on previous research by focusing on the specific relationship between youth in residential treatment and their therapists. Because there is no current literature examining the therapeutic relationship from an attachment perspective in adolescent residential treatment, this study offers a preliminary exploration from the unique and subjective perspective of the therapists.

Research Objectives

The present study seeks to understand therapist perceptions of the role of attachment in the therapeutic relationship with adolescents in residential treatment. Through semi-structured interviews, I explored three broad questions:

1. How do therapists who work in adolescent residential treatment view their role in the development of the therapeutic relationship? Do they place value on the role of attachment in treatment, regardless of theoretical orientation?
2. Do therapists consider themselves an attachment figure for their adolescent clients? Do they go as far as to consider the therapeutic relationship a specific attachment relationship? Through what theoretical lens do therapists experience challenges and setbacks in the therapeutic relationship with their adolescent clients?
3. How, if at all, do therapists consider interactions between their attachment style and the attachment style of their long-term adolescent clients? How do they manage attachment-based affect in the therapy room?

Methods

Qualitative Research Design

The philosophy/research paradigm behind this study was pragmatic social constructivism, as I was guided by a focus on local, socially constructed knowledge that is concerned with activity, action, and practice (Peterson & Peterson, 1997). The qualitative research design was drawn from constructivist grounded theory, as I wished to move toward the generation of a theory of understanding adolescent therapist perceptions of their roles. I was interested in determining if and when a course of more-intensive therapy with an adolescent becomes an attachment relationship and how therapists understand the meaning of such a transformation. I

see this depth exploration as a first step that may guide future data collection on the role of attachment within child and adolescent psychotherapy process and outcome.

Within constructivist grounded theory, data and analysis are generated from "shared experiences and relationships with participants" (Charmaz, 2006, p. 130). There is a focus on the study of "how," and, at times, "why" participants create meanings and action in particular situations (Charmaz, 2006).

Participants. The target population for the qualitative design was current and former adolescent therapists from a residential treatment setting located in the Greater New York City area. The recruitment strategy was purposeful sampling: I selected participants who would provide rich amounts of information for comprehensive exploration. Recruitment also entailed convenience sampling as I had permission from the administration to interview therapists. Specific criteria for participation in the proposed study included licensed or license-eligible mental health providers with graduate degrees with at least one year of experience working in a residential treatment setting which allowed for sufficient acclimation to the setting. In accord with sample size suggested by constructivist grounded theory research design, I interviewed eight participants.

Interview protocol/data sources. I conducted face-to-face interviews of 30–60 minutes duration as a way to draw out each participant's understanding and interpretation of her experience (Charmaz, 2006). Interviews were audiotaped and transcribed. A semi-structured format was utilized, as it allowed the participants and me the flexibility to further develop the responses to questions initially presented on the interview protocol. The interview protocol included initial open-ended questions, intermediate questions, and ending questions aimed to capture therapist perceptions regarding the role of attachment in the client–therapist relationship

in adolescent residential treatment. The interview protocol can be found in Appendix D.

I also asked participants to fill out a brief descriptive demographic questionnaire, which included Bartholomew and Horowitz's (1991) Relationship Questionnaire (RQ). The RQ is a brief four-item questionnaire intended to measure self-reported adult attachment style. The demographic questionnaire, including the RQ, can be found in Appendix C.

Procedure

The residential treatment setting where I conducted this study is located in the Greater New York City area. It is important to note that I am currently employed at this agency and received permission from the Vice President of Behavioral Health Services to move forward with the study. The letter of permission can be found in Appendix A.

Following approval by the agency's IRB and Antioch University New England's IRB, the Clinical Director received the description of study and informed consent and distributed this form via email to all therapists within the agency. I also distributed the description and consent form to therapists I personally knew who were no longer employed at the agency. The description of the study/informed consent details information about the project, its background and purpose, participation incentive, potential risks and benefits, and terms of confidentiality. The description of this study and informed consent can be found in Appendix B.

Once they received the email inviting them to participate, interested participants opened an attached PDF to find a description of the study and the informed consent. At the bottom of the informed consent, interested participants manually signed the form indicating that they read the form and consented to participate in the study. These participants then forwarded the signed consent form to my email referenced on the bottom of the form. Upon receipt of the signed form, I contacted participants by phone and/or email to answer any lingering questions or concerns and

to set up a face-to-face interview at their convenience.

When we met, I again told the participants about their role in the study, offered them the opportunity to ask any questions, and reminded them that I might want to contact them at a future date so they could clarify and/or confirm information. For example, I wanted to be able to ask them to look at the theoretical categories I distilled from all the interviews to get their thoughts and feedback. Before we began, participants received a $10 Starbucks gift card as a token of appreciation for their time.

I then had them fill out a brief questionnaire inquiring about demographics, work history, theoretical orientation, and self-assessed attachment style. The questionnaire can be found in Appendix C. We then discussed their experiences of conducting therapy with adolescents in residential treatment with a focus on their meaning-making about attachment and the therapeutic relationship (see Appendix D for a list of basic interview questions).

Interviews were audiotaped, transcribed, and coded according to Charmaz's (1996, 2006) constructivist grounded theory data analysis approach. As a way to ensure privacy, the audiotapes were password encrypted. Audiotapes were also transcribed verbatim in a password-encrypted document. Participants' names were not included on any documentation (i.e., questionnaire, interview protocol, or transcription of interview dialogue); instead, a number was assigned to each participant. All documents pertaining to the interviews were stored on a password-encrypted computer and/or a locked file cabinet to which only I had access. All relevant documents will remain safely stored until three years after the dissertation is officially completed and then all documents will be deleted and/or shredded.

Analysis

Constructivist grounded theory data analysis using the Charmaz (1996, 2006) approach

was utilized. Within this flexible approach to coding categories and identifying links among them, there is an emphasis on understanding rather than explaining. Constructivist grounded theory assumes a position of mutuality and reciprocity between researcher and participant (Mills, Bonner, & Francis, 2006). Therefore, crucial to this research design is the development of a partnership between researcher and participant—one that "enables a mutual construction of meaning during interviews and a meaningful reconstruction of their stories" (Mills et al., 2006, p. 8) into a grounded theory. Procedures outlined by Charmaz regarding data analysis for constructivist grounded theory included two phases of coding, initial coding and focused coding, as well as simultaneous memo-writing and theoretical sorting, diagramming, and integrating. The final stage of analysis in constructivist grounded theory is theory construction (Charmaz, 2006).

Initial coding. Within the phase of initial coding, data fragments were examined and coded for their action. Initial coding was conducted word-by-word, line-by-line, and/or incident-by-incident. Initial codes are conditional and grounded in the data; coders are urged to avoid the application of preconceived categories to the data in this stage (Charmaz, 2004, 2006).

Focused coding. This phase of coding was "less open-ended and more directed than line-by-line coding" (Charmaz, 1996, p. 40) and the additional forms of the initial coding phase. Within this phase of coding, significant and/or recurrent earlier codes from the initial coding phase were identified and categorized. In the focused coding stage, I made determinations about which initial codes "made the most analytic sense to categorize data incisively and completely" (Charmaz, 2006, p. 58). It is important to note that each protocol underwent the two phases of coding, initial coding and focused coding.

Memo-writing and conceptual categories. Writing memos or "informal analytic notes" (Charmaz, 2006, p. 87) is a crucial transitional step between data-gathering and writing drafts of

the paper in grounded theory. It encouraged me, as the researcher, to examine codes or ideas I had about codes in a flexible manner. Though there is no set method of memo-writing, I utilized early memos and advanced memos. For example, early memos were used to explore codes and identify categories and subcategories while advanced memos helped to make comparisons among categories and subcategories. Above all, the act of memo-writing served as a way to elevate focused codes to conceptual categories (Charmaz, 2004, 2006).

Theoretical sorting, diagramming, and integrating. Sorting, diagramming, and integrating categories comprise the next stage in constructivist grounded theory data analysis. Though none of these were required within constructivist grounded theory, they provided a format for organizing and integrating categories from previous stages. Sorting was a way to not only generate but also hone theoretical links among categories. The use of diagrams offered a tangible and visual representation of the categories and relationships among them (Charmaz, 2006).

Theory construction. As previously noted, the derived theory emphasized understanding rather than explaining. I endeavored to create connections between "local worlds and larger social structures" (Charmaz, 2006, p. 133) instead of linear reasoning.

Enhancing Rigor

To enhance rigor, I used detailed transcription skills and thick description. In addition, I enhanced the rigor of this constructivist grounded theory design through engaging in reflexivity.

Detailed transcription skills. For this study, I used audio recording and verbatim transcription. Not only is this the accepted norm within qualitative research, but this process allowed me to become accustomed to the data. Listening to the audio more than once enabled me to notice subtleties in communication (Markle, West, & Rich, 2011).

Thick description. Information-rich, thick description of all study components will permit those reading this study to determine if results can be transferred to further populations of interest. Comprehensive information regarding the nature of participant recruitment and criteria for participation is reiterated in the results section below. In addition, a brief questionnaire inquiring about demographics, work history, theoretical orientation, and self-assessed attachment style was included in the data collection. Following the semi-structured interviews, summary field notes were written with a reflection of the process. Detailed information about the interview setting (i.e., the residential treatment center) and any noteworthy incidents that transpired during the interview were also recorded. Records of all of the stages within grounded theory data analysis were kept throughout the entirety of the process.

Reflexivity. Reflexivity refers to "the generalized practice in which researchers strive to make their influence on the research explicit—to themselves, and often to their audience" (Gentles, Jack, Nicholas, & McKibbon, 2014, p. 1). As such, I not only considered but was also transparent about the ways in which my background influenced each stage of the research (i.e., focus of the study, methods, analysis, and discussion; Gentles et al., 2014). Doing so prevented my "tacit assumptions and interpretations [from being raised] to 'objective' status" (Charmaz, 2006, p. 132). For example, I have significant experience working in residential treatment and a strong bias towards attachment theory. In addition, I am currently employed at the agency participating in this study and many of the participants are my colleagues. Therefore, I was transparent with each participant regarding this information, and opened the conversation to any reactions and/or feedback they may have had in response.

Results

Description of Participants

The recruitment strategy for this qualitative study was purposeful sampling: I selected cases that would provide rich amounts of information for comprehensive exploration. Recruitment for this study further entailed convenience sampling, as I had permission to interview therapists. Specific criteria for participation in the study included licensed or license-eligible mental health providers with graduate degrees with at least one year of experience working in a residential treatment setting to allow for sufficient acclimation to the setting.

The population for this qualitative study included eight therapists specializing in the treatment of adolescents at a residential treatment center located in the Greater New York City area. Of the eight participants, six were current adolescent therapists and two were former adolescent therapists from this residential treatment center. All participants identified as female. Their age ranged between 25–49 years old. All participants identified as white and of non-Hispanic, Latino, or Spanish origin. Of the eight participants, six had completed a doctorate degree and two had completed a master's degree. In addition, six of the eight participants were licensed mental health providers. Lastly, four of the participants self-reported a secure attachment style, three self-reported a fearful attachment style, and one self-reported a preoccupied attachment style.

Overview

Constructivist grounded theory data analysis using the Charmaz (1996, 2006) approach was performed based on a semi-structured interview with all eight participants. Categories, subcategories, and meaning units were identified to generate an understanding of the role of

adolescent therapists engaged in intensive long-term treatment of complexly traumatized adolescents with a focus on the qualities of an attachment relationship.

Themes were organized into four categories: (a) Role of the Therapist, (b) Affect Management in/out of the Therapy Room, (c) Healing through Connection, and (d) Attachment in Residential is Fundamental. A qualitative data table can be found in Appendix E.

Categories, Subcategories, and Meaning-Units

Category one: Role of the therapist. The first category reflected participants' understanding of their role as a therapist in adolescent residential treatment in addition to the ways in which this role differs from the role of a therapist in outpatient or brief hospital settings. More specifically, participants described the ways in which their therapeutic style changed when they began working in adolescent residential treatment. Overall, therapists reported significant shifts in their role as a therapist in adolescent residential treatment. Four subcategories emerged from the data: (a) the therapist role in residential is an expansive one, (b) throw what you learned in school out the window, (c) authenticity and genuineness above all, and (d) be flexible and meet them where they're at.

Subcategory one: Therapist role in residential is an expansive one. Four participants remarked on the ways in which the role of a therapist in adolescent residential treatment expands far beyond the role of a therapist in a more traditional therapy setting. For example, Participant 7 reported the following:

> The role of a therapist in residential extends well beyond the conventional expectation, and so, for that reason, I do sometimes assume that like more caregiving responsibility while still maintaining a boundary of how can I utilize my role from a clinical standpoint to do corrective work.

Participant 8 shared the following:

> What's wonderful about a residential setting is that you have that moment where you catch yourself in the moment or later to either do some repair work or role model, whatever the case may be.

Participants also described specific ways in which their role changed as a therapist in adolescent residential treatment, such as boundary shifts. Participant 2 stated:

> I think that my boundaries have gotten a lot more flexible. I think that I used to maintain, like when I was working in outpatient, more rigid boundaries, where in residential, they have to become more flexible.

Overall, participants identified their roles as caretakers in various forms (i.e., mothers, older sisters, cousins, cooks, and teachers).

Subcategory two: Throw what you learned in school out the window. Four participants described their role as one they did not learn about in graduate school. Participants spoke to the notion that much of what you learn in graduate school does not fit with adolescents who have experienced chronic traumatic stress and/or complex/developmental trauma; more so, much of what you learn in graduate school does not fit with adolescents who have experienced chronic traumatic stress and/or complex/developmental trauma seen in residential treatment. One participant reflected, "You really can't rely on like classic technique. It's just not…with teenagers, um, in a residential setting, it just doesn't work that way" (Participant 7). Participant 2 stated the following:

> I think I just gave up on my own agenda in therapy. And I was like, "Do you just want to hang out today?" And then I sort of started calling her on her bullsh*t, too, because she would fake laugh at these things and I was like, "You're not enjoying this."

Subcategory three: Authenticity and genuineness above all. Three participants noted the immeasurable importance of being authentic and genuine in their role as a therapist working in adolescent residential treatment. A specific way in which therapists remarked on doing so related to therapists showing more emotion than they may have typically shown with clients in an outpatient setting. For example, Participant 6 stated:

> I think I've been more real. It's forced me to show more emotion in session or in meetings with them. You know, I think I've become more invested in them and in the work that I do with them.

Though initially mentioned in response to the interview question about a therapist's role in residential, the theme of an authentic and real relationship carried throughout the interviews. For example, Participant 5 shared the following, "I think my style with my clients is to be really authentic. Um, so it's like a more personal, ah, more professional version of my personal self."

Subcategory four: Be flexible and meet them where they're at. Five participants expressed the ability to be flexible as a major shift in their role when working with adolescents in residential treatment. When asked about her therapeutic style with youth in residential treatment, Participant 7 shared, "It's like an eclectic client-centered type of approach because you have to really be very flexible with our kids in terms of how to really reach them at a place of understanding." Another participant noted, "I think that my boundaries have gotten a lot more flexible" (Participant 2). Participants discussed flexibility across a range of domains; for example, the time, location, and overall make-up of therapeutic moments; and how to measure treatment progress and success. For example, Participant 6 reported the following:

> Those like in between session times are sometimes more important than the actual session times because you get the good at the time, you know what I mean. You can

> catch them in a moment when they're vulnerable and like willing to talk or they just, you know, something good happened and you're there and they want to tell you.

Participant 6 further commented on needed flexibility when measuring success and progress in adolescent residential treatment:

> I don't care how much, quote, progress they make therapeutically. If they can't trust an adult, if they can build a relationship and see that not every single adult is out to hurt them or out to, you know, do something bad to them, I think I did my job.

Category two: Affect management in/out of the therapy room. The second category described how therapists manage affect with their adolescent clients in residential treatment. Participants described the importance of being aware of affect—their own and the clients—as a central focus in the therapy. They also noted the ways that their own attachment styles might have an impact on their level of comfort with affect and their overall ability to manage it effectively and appropriately for the client. Two main themes emerged from the data: (a) attunement is key, and (b) therapist self-awareness.

Subcategory one: Attunement is key. Five participants described the significance of attuning to their adolescent clients in residential treatment, not only during individual therapy sessions but also within the therapeutic milieu setting. For example, Participant 7 reported the following:

> I will become emotional with a client if I feel like that's helpful to them but then again, the attuning is really important, knowing your client, knowing what's helpful or burdensome to them is really important.

Participant 8 reported the following:

> Obviously safety for myself and the child is always….is very key but it's one of those things where, um, it's important to be grounded where you're not trying to…you're not matching what's happening. You're trying to meet their needs. You're trying to figure out…you become hyper aware of voice, presence, um, to combat…and really go to a non-verbal place that they can respond to and hopefully feel safe.

Participant 5 further described the experience as "gauging where they're at." For example, she noted the importance of "knowing what their personal triggers are and knowing what might set them off and knowing what mood they're in today and knowing where they're at."

Subcategory two: Therapist self-awareness. Participants remarked on the importance of self-awareness when working with adolescents in residential treatment. They noted that their own attachment style showed up in their work, particularly with reference to their level of comfort with the expression of affect and their overall ability to manage it effectively and appropriately for the client. For example, Participant 2 reported the following:

> Just sort of monitoring your own emotional reactions to the client, like is this eliciting a visceral response because this is some unresolved issue of mine or is this reminiscent of an experience that other people might have in response to this person, so it's sort of paying attention to like where that's coming from and managing it.

Participant 8 remarked on her overall discomfort with hypo-aroused clients in comparison to hyper-aroused clients:

> I'm actually triggered by flat affect. That's actually tougher for me because, as you can see, I'm a talkative person so I tend to want to start doing the work for them or don't necessarily always feel comfortable in just being with a flat affect. Um, so in that case, I

> have learned to do a little bit better with being mindful of myself and my own triggers and letting the space happen and, um, learn how to pace the questions, learn how to not be so concerned about what I'm feeling but check in with that…and really understand the flat affect. You know, try to figure out what's going on with them that all of a sudden they become flat. So if it's affect that is really more aggressive or more hyper-aroused, in a weird sort of way, I'm actually more accustomed and comfortable with that.

Finally, Participant 8 shared the following:

> At the end of the day, you are an instrument, um, an essential one and the more self-aware of your attachment needs, their attachment needs, the better off you are going to be able to really help this person.

Category three: Healing through connection. The third category describes the quality of connection that therapists recognize in their work. The concepts of connection and safety—and the relationship between connection and safety—were widespread throughout all eight interviews. For example, when asked about the mechanism of change in therapy, Participant 7 exclaimed, "A feeling of safety. And a safe space for a lot of people means connectivity." Three main subcategories emerged from the data: (a) atypical moments of connection, (b) corrective relational experiences, and (c) internalizing the therapist.

Subcategory one: Atypical moments of connection. Seven participants described moments of connection with their adolescent clients in residential treatment, which were widely atypical in comparison to a more traditional outpatient therapy setting. Many of these moments occurred outside of the therapy room and outside of the weekly individual therapy session. For example, Participant 7 described a moment of connection with one of her most challenging clients:

> I offered to have group therapy outside on the basketball courts. This kid, I told him at

> the beginning of the group, you know, it's okay for you to sit out. In fact, you seem so dysregulated right now—in different words—it's probably better this time around. He took that as such a rejection that as we were out on the basketball court, he travelled with the chair out to throw it at me and when he threw it at me, he purposely missed me, which was the sweetest part of it all.

Though at first read it may be challenging to see this moment as one of connection, this participant understood her client's behavior not solely as an act of passive aggression but also a symbol of their challenging, though still meaningful, therapeutic relationship.

Additional participants described moments of intense emotion felt and expressed by both the therapist and the adolescent client. For example, Participants 6 and 8 both described moments where both therapist and client were sobbing together. Other participants described moments of connection during crisis intervention. Participant 5 reported a time where her client was absconding from campus walking in the street towards the train station. In her attempt to encourage her client to return to campus, she commented on the rain and not wanting her client to be cold or get sick. From this tiny, yet to her integral, moment of caretaking and offering of safety, she believed this intervention persuaded the client to make the decision to return to campus.

Subcategory two: Corrective relational experiences. Six participants described the notion of corrective relational experiences with their adolescent clients in residential treatment. For example, Participant 3 reported the following:

> I think a main objective of mine is to facilitate a therapeutic attachment, especially for youth in residential, as like a corrective relationship for these kids. I think it's a launching pad for the kids to realize that there are healthy caregivers out there and there are

opportunities to connect with individuals in a healthy way.

Though participants more often than not did not use this terminology, the essence of their description was of the significance of corrective relational experiences. Participant 8 stated the following:

> [I want to] create a safe enough space to be much more of a secure attachment, you know? To have that place where they can have a secure base from which they can sort of heal from what they've been through and start to explore the world in a whole different way.

Subcategory three: Internalizing the therapist. One participant (Participant 7) described a unique, yet powerful, experience of internalizing the therapist:

> But if you can sense in them that they feel empowered to confront that [discharge back into the community] then it's kind of like a segment of you is going with them because that's what you want them to internalize, is you have the strength, the power, and the resiliency to be able to do this without me.

Though this participant did not identify this experience as the mechanism of change in therapy, she described it as "the best you can hope for for your kids [your adolescent clients]."

Category four: Attachment in residential is fundamental. The fourth category captured the widespread theme of the prominence of attachment in adolescent residential treatment. Three subcategories emerged from the data: (a) the therapeutic relationship is a specific attachment relationship, (b) potential barriers and blind spots, and (c) training/education is needed.

Subcategory one: Therapeutic relationship is a specific attachment relationship. When asked whether or not participants conceptualized the therapeutic relationship as an attachment

relationship, five ultimately responded "yes." Participant 7 stated the following:

> I think it is 120% an attachment relationship, absolutely. In fact, I'm not sure if you asked me that question in a different way…to tell you how it's not [an attachment relationship]…I would be able to answer.

Another participant shared, "I think it's [attachment] the foundation of my practice at this point (Participant 7). Though many participants were quick to agree with conceptualizing the therapeutic relationship as an attachment relationship, others made it a point to express their hesitation with the idea. For example, Participant 4 reported the following:

> It's a tough one, because there's also balance. Just also being mindful of, um, minding that safe space but also being mindful of boundaries. And understanding that if there is a family involved, it's important to not only model that with them in the therapy sessions but to make sure that family is able to do that if possible if they're available.

This finding speaks to the hypothesis raised earlier suggesting apprehension among therapists about challenging or threatening the inviolable primary bond a child has with a parent by presuming to foster attachment in their younger clients.

Subcategory two: Potential barriers and blind spots. Four participants explored their understanding of why it was challenging to imagine the therapeutic relationship in residential work from an attachment frame. Participants discussed potential reasons related to fear, boundary issues, and—considering more systemically—a disregard for underserved populations in general. For example, Participant 6 stated, "People are maybe kind of afraid of what focusing on the relationship means." She further hypothesized one reason to be the potential for blind spots, as she stated, "You're just becoming so attached, you're going to have all these blind spots…but we know that attachment is much more complex than that." In contrast to Participant

6's hypothesis of others' potential experiences with boundary issues, Participant 1 discussed her hypothesis of her own experience with boundary issues as she reported, "No matter how much someone's [a client's] like, 'I love you,' you know, like, I just always have to remind myself, like, with my kids, I have to have, like a boundary."

Subcategory three: Training/education is needed. Four participants discussed the need for training and education surrounding the concept of attachment in residential treatment. Two of the four participants described a systemic misunderstanding of the therapeutic relationship and almost an undervaluing of it. For example, Participant 3 hypothesized, "It almost makes me feel as though, amongst researchers, that there isn't an understanding of the value of the relationship and the necessity and the importance of the relationship." In line with the hypothesis that the therapeutic relationship is undervalued, Participant 5 attributed the lack of research to working with an underserved population. She reported the following:

> I think our population is underserved. I think it's, kind of, overlooked and I know within helping professionals who are doing this research it shouldn't be but I still think that it might be a bit overlooked.

Participant 1 noted the need for more education on attachment in residential treatment for all staff members. For example, she stated, "Any residential I've ever had contact with, they really…they don't give as much weight to it [attachment] as they should…more education is needed."

In addition, though all of the participants expressed an understanding of the basic concepts of attachment theory, their knowledge of attachment styles and attachment theory as a model of psychotherapy widely varied.

Discussion

Constructivist grounded theory data analysis using the Charmaz (1996, 2006) approach was performed based on a semi-structured interview with eight adolescent therapists from a residential treatment center. Potential categories, subcategories, and meaning units were identified to generate an understanding of the role of adolescent therapists engaged in more intensive therapy with complexly traumatized adolescents in residential treatment with a focus on the qualities of an attachment relationship. While the individual experiences of the participants may not be completely generalizable to all therapists working with adolescents in residential treatment, their responses provided the opportunity to cultivate further understanding of the role of attachment in the therapeutic relationship in adolescent residential treatment. These findings have clinical implications for therapists working with adolescents in residential treatment; training implications for trainers and educators in residential treatment; and suggestions for future inquiry to add to the limited body of research examining the therapeutic relationship from an attachment perspective in youth treatment, as a whole.

Research Questions

The research questions which directed this study were as follows:

1. How do therapists who work in adolescent residential treatment view their role in the development of the therapeutic relationship? Do they place value on the role of attachment in treatment, regardless of theoretical orientation?
2. Do therapists consider themselves an attachment figure for their adolescent clients? Do they go as far as to consider the therapeutic relationship a specific attachment relationship? Through what theoretical lens do therapists experience challenges and setbacks in the therapeutic relationship with their adolescent clients?

3. How, if at all, do therapists consider interactions between their attachment style and the attachment style of their long-term adolescent clients? How do they manage attachment-based affect in the therapy room?

Research question one. The first question aimed to capture therapists' views of their role in residential treatment, specifically in the development of the therapeutic relationship. It was hypothesized that therapists would consider their role one of significant importance. Additionally, it was hypothesized that, despite theoretical orientation, value would be placed on the role of attachment in treatment. Results revealed that all eight therapists placed significant value on the role of attachment in therapy with their adolescent clients in residential treatment. In fact, all therapists declared fairly strongly that one could not do meaningful work without attending to the concept of attachment in some aspect within their relationships with their adolescent clients.

The first major category that emerged from the data reflected participants' understanding of their distinct role as a therapist in adolescent residential treatment. They noted the ways in which they came to conceive of their work differently than as a therapist in outpatient or brief hospital settings. Participants described how their therapeutic style changed when they began working in adolescent residential treatment. In particular, they discussed how their engagement was much more expansive now. They spoke to the particular importance of their authenticity, genuineness, and flexibility within this more intensive therapeutic relationship with adolescents.

The significance of adult authenticity and genuineness to forge these relationships has been noted in previous qualitative research (e.g., Manso et al., 2008) exploring the youths' perspectives on their relationships with direct care staff. Manso and colleagues found that the youths' views of the direct care staff—how staff behave and make them feel—have some

striking parallels to the therapists' understanding of how they need to show up to be most effective.

Of course, most therapists recognize that they must develop positive relationships with traumatized youth in order for the adolescents to progress in their treatment. What seems different here is the means by which residential therapists go in order to show up and be effective for their adolescent clients. For example, therapists working in adolescent residential treatment attend parent/teacher conferences, award ceremonies, and graduations; they assist their clients in cleaning rooms and completing daily chores; they take their clients out for lunch as rewards for positive behavior or to celebrate birthdays and other momentous occasions; they're present for manicures, hair appointments, or trips to the mall to get new clothes; they'll run after a client attempting to abscond from campus; or call a client in the evening or over the weekend who otherwise would not be receiving any incoming calls due to absence of family contact. These represent only a snapshot of the ways in which a therapist working in adolescent residential treatment shows up for their clients. This is not to say that therapists working in adolescent residential treatment do more or dedicate themselves more to their clients and their work than therapists working in alternate settings. What I believe it does say, however, is that working in adolescent residential treatment, in itself, lends itself to circumstances that, in outpatient settings, may more easily be considered boundary violations. It is interesting that in adolescent residential treatment, these are the circumstances that often strengthen the therapeutic relationship, facilitate corrective relational experiences, and foster more positive therapeutic outcomes.

While all participants acknowledged the importance of attachment in their work irrespective of their theoretical orientation—which participants identified as psychoanalytic/psychodynamic, developmental/attachment, relational, cognitive-behavioral,

behavioral, family systems, narrative, and humanistic/person-centered—it is very likely that they had disparate views of what that meant. For example, Participant 3 gave a nuanced account of the importance of attending to attachment styles:

> So there is a youth on the unit right now who sees another clinician. She's [the youth is] very avoidantly attached. Um, and that clinician struggles to maintain a relationship with her. And she and I are able to not only have a good therapeutic relationship, but also consistently maintain contact. And I tend to be a greater support for her, for whatever reason. And I think part of that is my understanding of why she avoids interaction; she needs space. Um, and just having that awareness [from my knowledge of my own attachment style] versus someone who doesn't have that attachment style [is helpful].

By contrast, Participant 5 was less clear, simply saying:

> Like the one client I was talking about in the beginning, she trusts people too much. She doesn't, you know, she is just so wanting people to meet her needs that she has an unhealthy sense of trust. She's very naïve and very vulnerable. Um, the client that I mentioned secondly, that has been maybe more guarded. That is their attachment style with me. Um, and again, I can be a tool because for that second client, I'm going to get through to them by honoring and letting them know that I know their independence, their own ability to take care of themselves; that I see that as a strength.

Overall, and consistent with participants' valuing of developing attachment bonds as part of their therapeutic roles, it seems that it would benefit them to know more about what attachment theory really means for their work; for example, perhaps they might become more effective with youth having disorganized attachment styles if they better understood the special challenges these adolescents face. Indeed, this finding suggests the need for further training and

education within adolescent residential treatment.

Even as the data appeared to confirm that therapists grasped that they were tasked with improving attachment security in the youth they treated, I was surprised to learn that some of them actually had such limited knowledge about attachment theory. As master's-level mental health providers increasingly are hired to work in residential treatment, it might behoove these agencies to offer more specific training and education of new employees regarding not only the general concept of attachment and its significance for healthy IWMs, but also more detailed information specific to attachment styles and how each one may behaviorally and emotionally present itself in the youth we are treating. Just as we may talk about "trauma" and be describing so many different kinds of adverse experiences and impacts, we may also be using the idea of "attachment" to cover a vast range of connections and devotions. We might all agree it's important, but have varied definitions about what we mean.

Research question two. The second question focused more specifically on therapists' views of the concept of attachment in the therapeutic relationship in adolescent residential treatment. It was hypothesized that therapists in adolescent residential treatment would consider themselves, to some extent, an attachment figure for their clients and that, in line with this, therapists would consider the therapeutic relationship a specific attachment relationship.

Results revealed that all eight participants considered themselves an attachment figure for their adolescent clients and talked about ways they functioned as such. They were all able to give examples of deep connection and expressed awareness of their special importance to an adolescent. Indeed, it was easy to engage them in coming up with examples of youth and therapy sessions in which their relationship made a difference. For example, Participant 2 shared the following:

> When I terminated with all my kids, I gave them letters that I had written just reflecting on our experiences together, and when I gave her hers, I had typed out a list of questions that we had made to ask her potential foster family; and I just poured my guts out in this letter and just told her everything that she meant to me and I would never do that in an outpatient setting ever. Um, I just really let go and she sort of read the letter very quietly, and she's not a crier, and she just had tears streaming down her face and she turned to me and just bear hugged me and we hugged for what felt like ten minutes. And just sobbed in each other's arms and I just felt like we're just always going to be connected.

Participant 6 shared the following:

> It was getting close to discharge and he was going to be stepping down to a group home because he didn't have anywhere else to go and, you know, I think he had like tried to get in touch with his aunt or contact her and just had been, you know, really not successful and he just like lost it. He was just, you know, "I need a family." And I'm sitting…I remember I had a bean bag chair where he was sitting and I was sitting at my desk and I like turned my chair away from him because I was starting to tear up and then I was just like, why am I going to leave this kid crying on the floor? And I sat down on the floor next to him, you know, and I, and I said, "You're right. You need a family and I'm so, so sorry that you don't have one." And we cried together.

This finding of a therapist's special importance to an adolescent in residential treatment mirrors the significant body of adult psychotherapy literature (Levy et al., 2011; Mallinckrodt et al., 1995; Mikulincer et al., 2013; Wallin, 2007) suggesting that a therapist similarly becomes an attachment figure for their traumatized adult clients. However, some made a distinction between being an attachment figure for a traumatized adolescent and viewing the therapeutic relationship

itself as a specific attachment relationship.

Five—but not all—of the participants held the view that the therapeutic relationship with their adolescent clients in residential treatment was, in fact, a specific attachment relationship. This finding parallels significant scholarship in adult psychotherapy research that supports an attachment framework for understanding the development of the therapeutic relationship (e.g., Mikulincer et al., 2013; Wallin, 2007). Though all recognized the importance of the concept of attachment within the therapeutic relationship, not all went as far as to consider the therapeutic relationship a specific attachment relationship. Participant 1, actually, spoke to the opposite notion as she noted the importance of being aware of the non-specificity of the therapeutic relationship. In her interview she stated, "I just always try to remind myself, like, it's not about me, like, I'm not a savior." Here the participant is acknowledging the idea that there is not something unique about her role in the attachment relationship developed through the therapy process. It is notable that while all participants understood that the youth might be getting attached to them and that they might be behaving in ways that intentionally fostered attachment security, some participants were adamantly unwilling to look at themselves as attachment figures.

These distinctions of importance are among the most interesting findings of this study. While therapists working with adults might more readily see themselves as attachment figures for their clients, there remains in the child and adolescent treatment world some reluctance and even fear about viewing themselves that way. Even youth in residential treatment without adequate parents still may not always find therapists who value themselves and the therapeutic relationship the way the youth do; they may feel that establishing and maintaining boundaries is more important. However, in adolescent residential treatment as opposed to everywhere else,

family reunification or primary attachment with a parent is often not possible. Of course, we respect that in the kid world, a therapist's reluctance may come from not wanting to usurp parental love or potentially threaten the sacred bond between parent and child. This way of thinking is all fine—but what if a therapist's love is all a youth can hope for? We know from the large and developing body of research (e.g., Buist et al., 2004; Hamre & Pianta, 2001; Schuengel & van IJzendoorn, 2001) that older children and adolescents benefit from multiple attachments in varied contexts. So why do we shy away from the possibility of fostering a healthy attachment relationship with an adult as a therapist working in adolescent residential treatment? Why do we shy away from the power of attachment, genuine and authentic relationships, and connection? Is it fear of boundary violations?

In addition to focusing our efforts on the avoidance of boundary faux pas, perhaps we might also steer focus in clinical forums/trainings (on a larger scale) and supervision (on a smaller scale) on the education and training of therapists about fostering effective dependence—in residential treatment, being reliable means not just being present for weekly individual sessions but showing up for youth at other times, too. Of course, it makes sense that therapists might endeavor to attend to strong boundaries with adolescents who have endured such terrible violations and whose mission now seems so singularly centered on testing whatever limits adults may set. But boundaries are only meaningful when they are accompanied by safe and reliable emotional connection, too. Otherwise they are more like walls than a frame around a safe area in which to play, work, and grow.

These interviews sparkled with examples of less orthodox strategies to form and sustain connections with complexly traumatized youth. A therapist follows an adolescent to the train station and expresses concern for her health; another crumples to the floor to share in his grief

over having no family available to take him in; a group therapist moves the work out to the basketball court; all engage in the myriad formal and informal contacts over the course of days and weeks that create and sustain the richer fabric of their unique dynamic connection. Residential therapists may be most effective when they are open to healthy ways to fortify attachment and engage in corrective relational experiences—both in and outside of the office space.

Results further revealed some additional information surrounding how therapists experience challenges and setbacks in the therapeutic relationship with their adolescent clients. Many of the therapists understood such ruptures through a trauma and/or relational/attachment lens. Though they may not all have used the terminology of attachment, they spoke in similar ways about difficulties they faced forming and sustaining the therapeutic relationship. Participants discussed specific clients with whom they did not have a connection and potential reasons for the lack of connection.

In analyzing the responses to this interview question, I took particular notice of how and where onus was placed. For example, some participants placed full onus on the client, stating, "He wouldn't connect to anyone; he had reactive attachment disorder;" or "It was because of his trauma." In contrast, other participants placed full onus on themselves. For example, Participant 7 stated, "I would go home thinking about this kid. How can I connect to him differently? What is it about me that he's not connecting to?" Lastly, Participant 2 discussed the notion of shared onus for the lack of connection by stating the following:

> She was so mean and, and everything she did was self-serving and she was a broken kid inside but it was so difficult to access that and it was just really hard to have empathy for her. I don't know. I spent so much time reflecting on this case. Like, why can't I get to

> this kid? I think I was still uncomfortable in my role as her therapist in residential. I wasn't sure where I fit in in that whole system and so I think that lent itself to a lot of obstacles. I don't think I was very authentic with her.

Participants also spoke to the quality of the therapeutic relationship that they worked to maintain with their longer-term clients; all eight spoke to the related themes of attending to connection and safety in their work. Many (N=6) also discussed their intent to show teens that this relationship would be different from their expectations based on past disappointing and unsafe experiences with adults; they could be safe and accepted for themselves here. This awareness of managing re-enactment therapeutically by offering corrective relational experiences is discussed widely in the attachment-based adult psychotherapy literature (Mikulincer et al., 2013; Roisman et al., 2002; Sauer at al., 2010).

For example, some participants in this study described moments where they were clear that old attachment models were operating: the youth, expecting to be treated as they had in the past, reenacted with the therapist aspects of previous distressing relationships. Participants were able to describe how they responded differently than the client's IWM might have predicted, leading to new feelings and understanding. For example, Participant 2 shared the following:

> I think it was just that empathy of being like, you're not a sh*thead kid. You're a kid who's been through a lot of sh*t and you're a person. And I think that empathy and also patience when she was screaming at me or when she was telling me I'm a piece of sh*t. I think knowing that and not taking it personally and having that patience and just being consistent with her allowed her to eventually trust me and form that relationship.

Even participants who were reluctant to view the relationship as a specific attachment recognized that these client–therapist specific attachment experiences, in accordance with a

strong therapeutic relationship, positively impacted the therapeutic process. Notably, too, several participants shared hope that these reparative experiences would impact subsequent relationships the clients will have with others outside of the therapeutic relationship. In attachment-based and other relational therapeutic paradigms, the hope and expectation is that a new relational model will take hold and pave the way for better connections down the road. For example, Participant 6 reflected:

> I don't care how much, quote, progress they make therapeutically. If they can trust an adult, if they can build a relationship and see that not every single adult is out to hurt them or out to, you know, do something bad to them, I think I did my job. And I'm, I'm very happy with that.

Research question three. This question focused more specifically on therapist and client attachment styles and affect management in the therapeutic relationship. It was hypothesized that therapists with a foundational understanding of attachment theory—and more specifically, attachment styles—would attend to and consider them as they worked to foster the therapeutic relationship. It was further hypothesized that therapists who identified with more affect-based theoretical orientations (e.g., attachment/developmental, relational, etc.) would attend to affect—both client and therapist affect—in the therapy room more than therapists who identified with less affect-based theoretical orientations (e.g., cognitive-behavioral, behavioral, etc.). Participants varied across paradigms in describing their primary theoretical orientation. For example, more than half (N=5) of the participants identified developmental/attachment, psychoanalytic/psychodynamic, and cognitive-behavioral as their primary theoretical orientations. However, given the attachment disruption inherent in placing youth in residential treatment and the likelihood of previous relational trauma, it was a bit surprising to discover that

not all participants had a firm grasp on attachment theory and how it might apply to psychotherapeutic interventions. On closer scrutiny of the responses it seems clear that participants with a doctorate degree presented with a more substantial knowledge base regarding the concept of attachment than their masters-level colleagues; those with less education knew relatively little about attachment styles. For example, they were not familiar with the idea that we might need to work differently depending upon whether a youth had a more anxious or avoidant strategy for managing relational stress.

As might be expected, participants did not all have secure attachment styles themselves as self-reported on the Relationship Questionnaire (RQ): four of the participants self-reported a secure attachment style, three self-reported a fearful attachment style, and one self-reported a preoccupied attachment style. This finding is in line with the adult literature on therapist attachment style, which summarizes the percentage of securely attached therapists to be around 60 percent, though results ranged widely on the methodology (Leiper & Casares, 2000; Strauss & Petrowski, 2017). And therefore, it makes sense to have an understanding of what occurs when our attachment styles interact with the, most often insecure, attachment styles of our teens. For example, a therapist with a preoccupied (or more anxious) attachment style may find themselves having more difficulty with a teen with a dismissive or fearful (or more avoidant) attachment style. They may find themselves doing more for those teens in an attempt to seek reassurance and relieve their own self-doubt which may in turn push their (avoidantly attached) teenage clients away.

Notably, however, all eight participants—even those with less affect-based theoretical orientations (i.e., cognitive-behavioral orientations)—discussed the importance of attending to strong affect as a principal focus in the therapy. Some also had insight into their own capacity to

manage feelings and how they handled youth presenting in hyper- and hypo-activated states. Similarly, six participants also reflected on the ways that their own attachment styles might have an impact on their level of comfort with affect and their overall ability to manage it effectively and appropriately for a particular client.

This finding is noteworthy for two reasons. First, adolescents in general, and traumatized adolescents in particular, tend to present in therapy with powerful—sometimes overwhelming—affective experiences. Rather than viewing emotional expression and dysregulation as an obstacle to effective treatment, participants understood that they needed to work *with* the affect—theirs included. And following from this, most participants were able to reflect, from an attachment lens, what might be emotionally challenging for them in certain therapeutic relationships. While the existing literature exploring the attachment security of adult therapists suggests that more secure therapists have better alliances and outcomes (e.g., Wallin, 2007), it is highly unlikely that all therapists drawn to working with traumatized teens will, in fact, have secure attachment styles. It is therefore very valuable that they know about how their particular insecurity shows up in their work so that they can remain reflective under stressful circumstances.

Instead of discussing their responses to this question using the language of attachment styles, some participants spoke more specifically about their level of comfort/discomfort with the extremes of arousal. In line with this, participants demonstrated an awareness of the client presentations they tend to interact with more favorably and, perhaps, more effectively. For example, Participant 8 discussed her discomfort with hypo-aroused clients who tend to down-regulate and shut down to manage overwhelming feelings (i.e., typically more representative of someone with an avoidant attachment style). She connected this to her

increased level of comfort with clients who present as hyper-aroused clients who tend to up-regulate and express strong emotion (i.e., typically more representative of someone with an anxious attachment style). This finding is similar to the adult psychotherapy literature on attachment styles (Janzen et al., 2010; Levy et al., 2011) indicating the importance of attending to client attachment styles so therapists might tailor their responses (e.g., not getting hyper-activated by a hyper-activated client) in order to facilitate greater safety and regulation. This finding, in particular, supports the need for supervision surrounding what hooks us and challenges us in particular ways—and of course how we, as therapists, need to possess adequate insight about why this is so.

Theory Description and Interpretation, Not Construction

Taken together, these findings begin to describe a theory of how adolescent therapists from residential treatment settings experience their roles and efficacy when a client–therapist relationship becomes an attachment relationship. Constructivist grounded theory methodology was implemented to analyze semi-structured interview data from adolescent therapists working in a residential treatment center. Results suggest that attachment is foundational in adolescent residential treatment, specifically within the development of the therapeutic relationship. More so, therapists in adolescent residential treatment conceptualize the therapeutic relationship with youth as an attachment relationship. Adolescent therapists in residential treatment further identify fundamental components of attachment theory such as affect management, attunement, and self-awareness as essential to the development of the therapeutic relationship.

Implications for Practice and Training

The results of this study yielded clinical implications for therapists working with adolescents in residential treatment and training implications for trainers and educators in

adolescent residential treatment.

Clinical implications. Findings from this study further support the importance of understanding the interpersonal dynamics of *both* the adolescent and therapist for optimal treatment planning. More specifically, it is helpful to pay explicit attention to client and therapist attachment styles and the possible ways they might interact. Part of early and ongoing supervision and treatment planning might include consideration of an adolescent's attachment style. Therefore, quantitative and qualitative measures of adolescent attachment should be accessible for therapists working in adolescent residential treatment. Building an awareness of the client's attachment style will lend itself to a therapist's increased ability to tailor regulatory interventions that offer corrective relational opportunities.

In line with an awareness of the client's attachment style, these findings similarly suggest that therapists consider their own models of relationship to better reflect on how a particular youth will "press their buttons." With such an awareness of our own attachment style as therapists, we are better able to identify and manage our triggers and challenges within the therapeutic relationship. As a whole, these findings underscore the significance of supervision, the therapist's own therapy, and adequate time for reflection. Adolescents in residential treatment are among the most challenging clients to have; it is virtually guaranteed that their emotionality will, at some point, lead their therapist outside of an established comfort zone.

Training implications. Results of this study suggest that adolescent residential treatment programs might benefit from offering significantly more education and training regarding attachment theory and its applicability to all aspects of a program, from the milieu to the classroom to the cafeteria. Such broad training might benefit employees across campus—including all disciplines and education levels (i.e., direct care staff, masters-level

therapists, doctorate-level therapists, caseworkers, teachers and paraprofessionals, recreational and vocational staff, nursing staff, and administrators—even cafeteria staff)—in adolescent residential treatment. Since the masters-level participants clearly had less exposure to attachment theory—and many residential treatment programs have few doctoral-level therapists—the need for interdisciplinary training seems paramount. It may prove fruitful to provide specific education and training related to early adversity and attachment styles; the subsequent development of particular internal working models of self, relationships, and the world; the interaction between the adult and adolescent attachment styles; and potential interventions that consider whether adolescents dysregulate by becoming hyper- or hypo-activated—often associated with the history of how they learned to handle relational stress.

Limitations

Limited generalizability. Due to the overall feasibility of completing a doctoral dissertation and the convenience of selecting an available study population (with limited number of therapists working in the agency), conducting interviews to the point of saturation was not possible. Perhaps, therefore, information that would have added to an understanding of a category or subcategory may have been missed. In addition, this study only examined therapists from one residential treatment setting. This methodology makes it difficult to determine how the experiences, perceptions, and interpretations of the participants in this study might be unique to the single treatment program. There is no way to know if the same data would have emerged from a wider range of participants, working in different settings, and interviewed for a longer time or over time.

An additional limitation includes the notion that my qualitative data were collected entirely from interviews and one small attachment measure as opposed to multiple sources of data

(observations, documents, etc.) frequently used in qualitative design (Patton, 2002). Lastly, this study is limited by the lack of previous research from which to compare the findings. Consequently, it serves as a first, exploratory step in developing new ways of understanding the therapeutic relationship from an attachment perspective in adolescent residential treatment.

My role as researcher. An additional limitation regards my role as both the researcher and as a therapist working in adolescent residential treatment. Not only do I have significant experience working in these settings, but I also possess a strong bias towards attachment theory. In addition, I am currently employed at the agency in this study; I work closely with many of the participants as my colleagues, as well. Though I was transparent with each participant regarding this information and opened the conversation to any reactions and/or feedback they may have had in response, it is possible this influenced how the participants responded to the interview questions. Overall, my role as the researcher likely influenced the process and outcome of this research, as a whole (Patton, 2002). However, it is also important to note that constructivist grounded theory is a theory dependent on the researcher's view. It does not and cannot stand outside of it; theory here is an interpretation of the researcher's perspective which I have aimed to be as transparent about as possible both with the subjects and in the analysis and interpretation of data.

Suggestions for Future Inquiry

Findings from this study add to the limited body of research examining the therapeutic relationship from an attachment perspective in adolescent residential treatment and youth treatment, as a whole. Future research should continue to explore the therapeutic relationship from an attachment perspective in adolescent residential treatment from a larger, more representative group of therapists working in multiple residential treatment settings. In addition,

future research might look at treatment dyads, exploring the specific attachment relationship from both the viewpoints of the therapists and their adolescent clients.

As findings from related research in the adult psychotherapy world suggest, a fruitful area of exploration might be to investigate more specifically, how attachment styles impact the therapeutic relationship, therapeutic process, and therapeutic outcome in work with adolescents. One implication of this inquiry might be, for example, the discovery that therapists choosing to work intensively with traumatized teens have a greater likelihood of attachment insecurity than other therapists—or that their insecurity compromises treatment efficacy with such challenging clients. Such findings might lead us to provide models of training and supervision for therapists in these settings that offer them better understanding and support through the attachment lens, perhaps improving treatment outcomes and reducing compassion fatigue and distress among therapists.

As a whole, findings from this study begin to support the transtheoretical implications of the concept of attachment for optimal treatment planning in adolescent residential treatment. There is thus a need for therapists from different theoretical orientations to acknowledge, consider, and attend to the concept of attachment, specifically when working with youth in adolescent residential treatment. Future research should continue to explore, in more depth, the transtheoretical implications of the concept of attachment in adolescent residential treatment.

Researcher's Personal Reflections

As previously mentioned, engaging in reflexivity is an integral way to enhance rigor in constructivist grounded theory design. This process involves the researcher's transparency and authenticity regarding any thoughts, feelings, reactions, interpretations, and/or biases that arise throughout the research process. As a whole, I experienced each participant to be quite open,

honest, and forthcoming throughout the interview. All appeared engaged throughout the interview and expressed an interest and curiosity in my dissertation and its findings.

Many of the interviews brought up significant emotions for me. In fact, there were moments in three of the interviews that caused me to feel teary. I noticed that these moments occurred when participants described poignant experiences of connection with their clients which reminded me of my own moments of connection with clients who were particularly special to me. In some way, I feel that my tears signified the level of connection and authenticity I experienced with the participants during the interview process. I believe there was a level of felt safety between the participants and me, and I hypothesize this may have been because of my previous relationships with them as my colleagues—and friends. Beyond my collegial relationships with the participants, I also have personal relationships, strong and meaningful connections, with a few of the participants as my friends. All in all, it is possible my former relationships with the participants, on both the collegial and personal level, impacted the interview process and outcome.

There were additional, though fewer, moments where I noticed I was controlling my emotional responsiveness. I was occasionally surprised when a participant spoke about her work in a way that was so disparate from my own. I was curious to find instances when participants shared views that did not align with my beliefs surrounding attachment theory and its applicability to the therapeutic relationship in adolescent residential treatment. In being aware of these biases, I believe I was able to manage them appropriately and ensure they did not impact my follow-up questions or how questions were phrased. Indeed, I was also even a little grateful to find some discrepant experiences that did not fit neatly into attachment language and theory.

Overall, I found the interview process to be rewarding, educational, and inspiring. It

reaffirmed why I chose this topic for my dissertation. It reignited my passion and drive to continue sharing the wonders of attachment theory and its applicability to the therapeutic relationship in adolescent residential treatment, and I am thankful for my participants' generous willingness to take time out of their busy schedules to speak with me.

Conclusion

In this qualitative study, I explored therapist views of the therapeutic relationship in adolescent residential treatment from an attachment perspective. I employed constructivist grounded theory data analysis of semi-structured interviews with residential therapists to explore their views of the role of attachment in the therapeutic relationship with their adolescent clients. The results underscore the creative and varied role that therapists take on to work in adolescent residential treatment; the importance of affect management, attunement, and self-awareness within the therapeutic relationship; the healing nature of relationship, connection, and feelings of safety with adolescents; and the concept of attachment as fundamental in adolescent residential treatment. Continued investigation of the healing significance of the therapeutic relationship in adolescent residential treatment and the role of attachment in understanding and treating these teens should remain a focus of child and adolescent psychotherapy research.

Adolescent residential treatment is truly unique; it is a longer-term intervention for teens that takes them from home and community and provides, instead, an entirely different context among strangers, in which to grow up. The success of adolescent residential treatment depends in no small part on the quality and safety of the close relationships the teen is able to forge while there. Within every relationship in adolescent residential treatment—including the therapeutic relationship—the youth can find new opportunities for growth, learning, healing, connection, and change.

However, the focus of treatment in these settings is so often on behavioral change—behavioral motivation programs implemented on the milieu level and cognitive behavior therapy and behavior management programs implemented on the clinical level. And with this primary attention on the teen's behavior, we can lose sight of the relational damage that they have survived in their short lives; we may even overlook how starved they are for meaningful connection and the fundamental importance of relationship for fostering growth and healing that underlie enduring behavioral change.

The importance of relationship, speaking to the components of attachment theory, is sprinkled throughout every response to every question throughout each interview in this study. And yet, therapists working with youth traditionally shy away from acknowledging the power of the attachment relationship, how transformative it can be for teens to have, perhaps for the first time in their lives, trustworthy and authentic human connections. Perhaps we guard the safe and clear boundaries for solid legal and ethical reasons; maybe we do it out of fear of feeling too much, or not wanting to matter so much that we cause harm to a vulnerable youth, or not knowing what to do with all the affect once it comes roaring in. It is such challenging work: it cannot be done well without education, training, and solid supervision. The ultimate reward of an attachment relationship is that it gives complexly traumatized youth what they are not only longing for but also deserve: a safe haven and a secure base, enduring connections, and with that, above all, the transformative experience of trustworthy relationships.

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Appendix A
Permission to Participate in Research
(for Vice President of Behavioral Health Services)

Hello,

My name is Lisa Milone, and I am a doctoral candidate in Antioch University New England's Clinical Psychology program. I am working on my dissertation supervised by Martha Straus, Ph.D. My project will explore therapists' views of the role of attachment in residential treatment settings for adolescents.

Therapists in residential treatment frequently have intense and frequent contact with adolescents who have previously endured unsafe and unpredictable relationships with adults. Indeed, the extended connection with a therapist in more intensive care is often the first stable and consistent relationship an adolescent may have ever had. Despite the fact that child and adolescent therapy may, for all intents and purposes, function as the safe haven and secure base common to all attachment relationships, research on child and adolescent treatment has been very slow to think about child and adolescent therapy as an attachment relationship.

In contrast to adult research exploring attachment in psychotherapy in great depth and the therapists' attachment style in treatment, it is still widely held that for children, the attachment relationship should develop with caregivers; therapists might even be overstepping to think of the therapeutic relationship as attachment. Consequently, therapists who experience and recognize attachment bonds with their adolescent clients have little guidance on either how typical or how useful this framework might be for enhancing therapeutic outcomes.

I am asking for your permission and help recruiting participants. They must be licensed or license-eligible therapists who have worked with children and/or adolescents in residential care for a minimum of one year. Those who consent to participate will be asked to fill out one brief demographic questionnaire and participate in a semi-structured interview, which will take about 45–60 minutes to complete. Only I will see the results of the questionnaire and have access to the information obtained through the interviews. While the participants will remain anonymous, I would be happy to share the overall results of the study with you and your agency.

I would greatly appreciate your help. I will follow up with this letter with an email and/or phone call to see if you have any questions or concerns. However, please feel free to contact me sooner if you so choose.

Thank you!
Lisa

Lisa Milone, M.S., M.S.
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Appendix B
Description of Study and Informed Consent

Study Title: Therapist Attachment and Meaning-Making in Adolescent Residential Treatment
Principal Investigator: Lisa Milone, M.S., M.S **Sponsor:** Antioch University New England

Introduction
This consent form will give you the information you will need to understand why this research study is being done and why you are being invited to participate. It will also describe what you will need to do to participate as well as any known risks, inconveniences, or discomforts that you may have while participating. We encourage you to ask questions at any time. If you decide to participate, you will be asked to sign this form and it will be a record of your agreement to participate. You will be given a copy of this form to keep.

Purpose and Background
You are invited to participate in a research study. This study will explore therapists' views of the therapeutic relationship from an attachment perspective in adolescent residential treatment. As a therapist in adolescent residential treatment, you have been identified as a possible participant for this research.

What is Involved in the Study?
If you decide to participate, you will be asked to complete a brief demographics questionnaire and participate in a face-to-face interview with the researcher. The total process will take about 45–60 minutes and will be conducted in an office on the grounds of the agency. Based on your responses, you may be contacted via a brief phone call or email for clarification and/or confirmation of information.

Risks
Participation in the study may involve some emotional risk, as you will be asked to talk about your feelings toward past and current clients while working in residential treatment. Hearing, thinking about, and answering the interview questions may cause emotional distress to some participants. You are free to take a break or stop at any time if you get uncomfortable or feel too distressed.

Benefits
It is reasonable to expect benefits from this research. For example, you may benefit from talking about your past and current clients. Beyond having the opportunity to share your reflections and expertise, I cannot guarantee that you will personally be helped by taking part in this study. Others may be helped by the information you share. These people could include other therapists, students interested in becoming therapists in residential treatment, and adolescents in residential treatment.

Confidentiality
Steps will be taken to keep information about you confidential, and to protect it from unauthorized disclosure, tampering, or damage. All interview responses will remain anonymous. Although some of your brief quotes may be used, your name and identifying information will not be connected in any way to the quotes. Numerical code names will be assigned to each participant. These codes will be used on all research notes and documents. A password will be required to access the electronic survey data for added protection. Only I will have access to this password. Consent forms will be kept separate from data with coded ID numbers to further ensure identity protection.

Steps will also be taken to maintain the confidentiality of any youth discussed throughout the interview. Therefore, the names of youth, from [Agency Name] or any other agency, cannot be used during the interview. They will not be recorded on audio tapes, research notes, or any other document.

Your Rights as a Research Participant
Participation in this study is voluntary. You have the right not to participate at all, or to leave the study at any time. You may skip any question you do not wish to answer. Deciding not to participate or choosing to leave the study will not result in any consequence or loss of benefits. It will not harm your relationship with [Agency Name] in any way.

Incentive
Individuals who choose to participate will receive a $10 Starbucks gift card at the beginning of the interview.

Contact Information
If you have any questions about this study, contact:
Lisa Milone
Telephone: xxx-xxx-xxxx
Email: xxxx@xxxxxxxx.edu

If you have any questions about your rights as a research participant, contact:
Kevin Lyness, Chair of Antioch University New England IRB
Telephone: 603-xxx-xxxx
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or:

Shawn Fitzgerald, Provost & CEO of Antioch University New England
Telephone: 603-xxx-xxxx
Email: sfitzgerald@antioch.edu

Documentation of Consent
If I choose to manually or electronically sign this form below, it will indicate that I have read this form and have consented to participate in the study described above. Its general purposes, the details of participation, and possible risks have been explained. I understand I can withdraw at any time.

_____ _____

Signature of Participant **Date**

Appendix C
Demographics Questionnaire

What is your age?

☐18–24 ☐25–29

☐30–34 ☐35–39

☐40–44 ☐45–49

☐50–54 ☐55–59

☐ 60–64 ☐ 65–69

With which gender identity do you most identify?

☐Female ☐Male

☐Transgender female ☐Transgender male

☐Gender Variant/Non-conforming ☐Not Listed _____

☐Prefer Not to Answer

Are you of Hispanic, Latino, or Spanish origin?

☐Yes ☐No

How would you describe your race? Please mark all that apply.

☐America Indian or Alaska Native ☐Asian

☐Black or African American ☐Native Hawaiian or Other Pacific Islander

☐White ☐Prefer Not to Answer

What is the highest degree or level of school you have completed?

☐Master's Degree

☐Doctorate Degree

Are you a licensed or non-licensed professional?

☐Licensed

☐Non-Licensed

How many years have you been a therapist?

☐Less than 2 years ☐3–5 years

☐5–10 years ☐10–15 years

☐More than 15 years

How many years have you been a therapist at a residential treatment setting?

☐Less than 2 years ☐3–5 years

☐5–10 years ☐10–15 years

☐More than 15 years

With which theoretical orientation(s) do you most identify? Please mark all that apply.

☐Psychoanalytic/Psychodynamic ☐Relational

☐ Cognitive-Behavioral ☐ Behavioral

☐ Narrative ☐ Family Systems

☐ Humanistic/Person-Centered ☐ Developmental/Attachment

☐_____

With which theoretical orientation(s) have you been exposed to? Please mark all that apply.

☐ Psychoanalytic/Psychodynamic ☐ Relational

☐ Cognitive-Behavioral ☐ Behavioral

☐ Narrative ☐ Family Systems

☐ Humanistic/Person-Centered ☐ Developmental/Attachment

☐_____

Please complete the following scale:

Scale:
Following are four general relationship styles that people often report. Place a checkmark next to the letter corresponding to the style that best describes you or is closest to the way you are.

____ A. It is easy for me to become emotionally close to others. I am comfortable depending on them and having them depend on me. I don't worry about being alone or having others not accept me.

____ B. I am uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I worry that I will be hurt if I allow myself to become too close to others.

____ C. I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them.

____ D. I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me.

Now please rate each of the relationship styles above to indicate how well or poorly each description corresponds to your general relationship style.

Style A

1	2	3	4	5	6	7
Disagree Strongly			Neutral/ Mixed			Agree Strongly

Style B

1	2	3	4	5	6	7
Disagree Strongly			Neutral/ Mixed			Agree Strongly

Style C

1	2	3	4	5	6	7
Disagree Strongly			Neutral/ Mixed			Agree Strongly

Style D

1	2	3	4	5	6	7
Disagree Strongly			Neutral/ Mixed			Agree Strongly

Appendix D
Interview Protocol

ID Number: _____

1) Please tell me about your therapeutic style with your clients.
   Prompts:
   a. How, if at all, has it changed since working with youth in residential treatment?
   b. How do you manage client affect in the therapy room?
   c. How do you manage your own affect in the therapy room?
   d. How, if at all, do you adjust your role as a therapist with youth in residential treatment?

2) Please tell me about a client (here, or at another residential treatment setting) with whom you had a close connection.
   Prompts:
   a. For how long did you work with this client?
   b. What was it about the client that may have made it easier to connect?
   c. What was it about you that may have made it easier to connect?
   d. Tell me your most memorable moment with this client.
   e. Tell me about the level of parental/family involvement with this client.

3) Please tell me about a client (here, or at another residential treatment setting) with whom you did not connect.
   Prompts:
   a. For how long did you work with this client?
   b. What was it about the client that made it difficult to connect?
   c. What was it about you that may have made it difficult to connect?
   d. Tell me your most memorable moment with this client.
   e. Tell me about the level of parental/family involvement with this client.

4) Please tell me your familiarity with the concept of attachment and its applicability to psychotherapy.
   If little familiarity:
   a. Tell me your conceptualization of the therapeutic relationship.
   b. Why is the therapeutic relationship important from your perspective?
   c. What do you see as the mechanism of change in psychotherapy?

5) Please describe the role attachment plays in your therapeutic relationships with your clients.
   Prompts:
   a. In what ways, if any, have you functioned as an attachment figure for your clients?
   b. How, if at all, has establishing an attachment relationship with your client impacted the treatment process?
   c. How, if at all, has establishing an attachment relationship with your client impacted the treatment outcome?

6) Please describe the role of attachment styles in your therapeutic relationships with your clients.

    Prompts:

    a. How has your attachment style impacted your therapeutic relationships with your clients?
    b. How has the attachment style of your clients impacted your therapeutic relationships?
    c. Please tell me about the interactions between both your attachment style and the attachment style of your clients.

7) Please describe your thoughts and/or feelings about conceptualizing the therapeutic relationship from an attachment perspective in adolescent residential treatment.

    a. How is this framework useful to you? If not, why?
    b. Why do you think this framework is not widely studied or employed in child and adolescent psychotherapy?
    c. What might your supervisor think of you employing this framework?

Comments:

_____
_____
_____
_____

Appendix E
Qualitative Data Table 1

Category	Subcategory	Meaning-Unit/Quote
1. Role of Therapist	Therapist role in residential is an expansive role	The role of therapist in residential extends well beyond the conventional expectation and so for that reason I do sometimes assume that like more caregiving responsibility while still maintaining a boundary of how can I utilize my role from a clinical standpoint to do corrective work. –Participant 7 I think that my boundaries have gotten a lot more flexible. I think that I used to maintain, like when I was working in outpatient, more rigid boundaries, where in residential, they have to become more flexible. –Participant 2 What's wonderful about a residential setting is that you have that moment whether you catch yourself in the moment or later to either do some repair work or role model, whatever the case may be. –Participant 8
	Throw what you learned in school out the window	You really can't rely on like classic technique. It's just not…with teenager, um, in a residential setting, it just doesn't work that way. –Participant 7 I think I just like gave up on my own agenda in therapy. And I was like, "Do you just want to hang out today?" And then I sort of started calling her on her bullsh*t, too, because she would fake laugh at these things and I was like, "You're not enjoying this." –Participant 2
	Authenticity and genuineness above all	I think my style with my clients is to be really authentic. Um, so it's like a more personal, ah, more professional version of my personal self. –Participant 5

		I think I've been more real. It's forced me to show more emotion in session or in meetings with them. You know, I think I've become more invested in them. –Participant 6
	Be flexible and meet them where they're at	Like an eclectic client-centered type of approach because you have to really be very flexible with our kids in terms of how to really reach them at a place of understanding." –Participant 7
		I think that my boundaries have gotten a lot more flexible. I think that I used to maintain, like when I was working in outpatient, more rigid boundaries, where in residential, they have to become more flexible. –Participant 2
		Those like in between session times are sometimes more important than the actual session times because you get the good at the time, you know what I mean. You can catch them in a moment when they're vulnerable and like willing to talk, or they just, you know, something good happened and you're there and they want to tell you. –Participant 6
		I don't care how much, quote, progress they made therapeutically. If they can't trust an adult, if they can build a relationship and see that not every single adult is out to hurt them or out to, you know, do something bad to them, I think I did my job. –Participant 6
2. Affect Management in/out of the Therapy Room	Attunement is key	I will become emotional with a client if I feel like that's helpful to them but then again, the attuning is really important, knowing your client, knowing what's helpful or burdensome to them is really important. –Participant 7

	Obviously safety for myself and the child is always….is very key but it's one of those things where, um, it's important to be grounded where you're not trying to…you're not matching what's happening. You're trying to meet their needs. You're trying to figure out…you become hyper aware of voice, presence, um, to combat…and really go to a non-verbal place that they can respond to and hopefully feel safe. –Participant 8
Therapist self-awareness	Just sort of monitoring your own emotional reactions to the client, like is this eliciting a visceral response because this is some unresolved issue of mine or is this reminiscent of an experience that other people might have in response to this person, so it's sort of paying attention to like where that's coming from and managing it. –Participant 2
	I'm actually triggered by flat affect. That's actually tougher for me because, as you can see, I'm a talkative person so I tend to want to start doing the work for them or don't necessarily always feel comfortable in just being with a flat affect. Um, so in that case, I have learned to do a little bit better with being mindful of myself and my own triggers and letting the space happen and, um, learn how to pace the questions, learn how to not be so concerned about what I'm feeling but check in with that…and really understand the flat affect. You know, try to figure out what's going on with them that all of a sudden they become flat. So if it's affect that is really more aggressive or more hyper-aroused, in a weird sort of way, I'm actually more accustomed and comfortable with that. –Participant 8

		At the end of the day, you are an instrument, um, an essential one and the more self-aware of your attachment needs, their attachment needs, the better off you are going to be able to really help this person. –Participant 8 Like I can't be like, oh, my God, come here, let me hug you and take care of you…when the kid is pushing me away, you know? So I definitely had to sit with that, um, and it can, um create a barrier I think when they don't match up. –Participant 6
3. Healing through Connection	Atypical moments of connection	I think it was just that empathy of being like you're not a sh*thead kid. You're a kid who's been through a lot of sh*t and you're a person. And I think that empathy and also patience when she was screaming at me or when she was telling me I'm a piece of sh*t. –Participant 2 I offered to have group therapy outside on the basketball courts. This kid, I told him at the beginning of the group, you know, it's okay for you to sit out. In fact, you seem so dysregulated right now—in different words—it's probably better this time around. He took that as such a rejection that as we were out on the basketball court, he travelled with the chair out to throw it at me and when he threw it at me, he purposely missed me, which was the sweetest part of it all. –Participant 7

	Corrective relational experiences	I don't care how much, quote, progress they make therapeutically. If they can't trust an adult, if they can build a relationship and see that not every single adult is out to hurt them our out to, you know, do something bad to them, I think I did my job. –Participant 6
		[I want to] create a safe enough space to be much more of a secure attachment, you know? To have that place where they can have a secure base from which they can sort of heal from what they've been through and start to explore the world in a whole different way. –Participant 8
		I think a main objective of mine is to facilitate a therapeutic attachment, especially for youth in residential, as like a corrective relationship for these kids. I think it's a launching pad for the kids to realize that there are healthy caregivers out there and there are opportunities to connect with individuals in a healthy way. –Participant 3
	Internalizing the therapist	But if you can sense in them that they feel empowered to confront that then it's kind of like a segment of you is going with them because that's what you want them to internalize, is you have the strength, the power, and the resiliency to be able to do it without me. –Participant 7
4. Attachment in Residential is Fundamental	Therapeutic relationship is a specific relationship	I think it is 120% an attachment relationship, absolutely. In fact, I'm not sure if you asked me that question in a different way…to tell you how it's not [an attachment relationship]...I would be able to answer. –Participant 7

	I think it's the foundation of my practice at this point. –Participant 2
Potential barriers and blind spots	You're just becoming so attached, you're going to have all these blind spots...but we know that attachment is much more complex than that. –Participant 6
	People are maybe kind of afraid of what focusing on the relationship means. –Participant 6
	No matter how much someone's like, 'I love you,' you know, like, I just always have to remind myself, like, with my kids, I have to have, like a boundary. –Participant 1
Training/education is needed	It almost makes me feel as though, amongst researchers, that there isn't an understanding of the value of the relationship and the necessity and the importance of the relationship. –Participant 3
	I think our population is underserved. I think it's, kind of, overlooked and I know within helping professionals who are doing this research it shouldn't be but I still think that it might be a bit overlooked. –Participant 5
	Any residential I've ever had contact with, they really…they don't give as much weight to it [attachment] as they should…more education is needed. –Participant 1

Appendix F
Permission to Use Relationship Questionnaire (RQ)