

Examining the process of change for adolescent girls on probation in a  
residential treatment center

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Thesis submitted to the faculty of the Virginia Polytechnic Institute and State  
University in partial fulfillment of the requirements for the degree of

Master of Science in  
Human Development

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April 28<sup>th</sup>, 2010  
Falls Church, Virginia

Keywords: process of change, residential treatment

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## ABSTRACT

The purpose of this qualitative study is to explore the factors that contribute to client behavior change and motivation during residential treatment for adolescent females on probation. Data were obtained through retrospective individual interviews with residents of a residential treatment center in Northern Virginia. Semi-structured, open-ended questions were asked in order to obtain a rich description of each girl's experience of change. The results illuminated specific aspects of the treatment program that were most helpful to the participants. By analyzing these data, a specific process of change was developed for this unique population. Participants in the current study reported relationships with staff and their families as very important in terms of making changes. It seems the attachments they were able to establish were a significant factor in change. Through the lens of attachment theory, it is hypothesized that participants' relationships with staff were instrumental in helping them to make changes, as these relationships offered a secure base from which to explore themselves. In the context of an alternative attachment, the current study could be beneficial in helping counselors view themselves as alternative attachment figures, and help them to be more intentional about how they use this in treatment.

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## CHAPTER 1

### INTRODUCTION

#### Statement of the Problem

The purpose of this qualitative study is to explore the factors that contribute to client behavior change and motivation during residential treatment for adolescent females on probation. This issue is of concern for several reasons. First, the female proportion of delinquency cases increased steadily from 19% in 1991 to 26% in 2002 for the crimes of aggravated assault, simple assault, burglary, larceny-theft, motor vehicle theft vandalism, weapons law violations, liquor law violations, and curfew and loiter law violations (Synder & Sickmund, 2006).

Second, research has shown that females are a unique population and have different needs than that of their male counterparts (Bergsmann, 1989). It has been suggested that this population has substantial family dysfunction, behavioral problems, mental health issues, substance abuse and past trauma that might better be treated in a diversion program than in a detention center (Cuellar, McReynolds, & Wasserman, 2006). There is a significant amount of literature suggesting that institutional responses to juvenile crime are not helpful in terms of preventing recidivism in females (Dembo, Wareham, Chirkos & Schemelder, 2005). Under the Enhanced Mental Health Services Initiative established in 2000, the Special Needs Diversionary Program (SNDP) was created for juvenile offenders with mental health disorders. The study consisted of 148 youths who were arrested primarily for status offenses such as running

away and underage drinking. Youth on a waiting list for treatment were used as a control group. Over a one-year period, 63 fewer youths were arrested out of every 100 youths served and individuals who completed treatment had a lower probability of being re-arrested for any offense in the future (Cuellar et al., 2006). This finding suggests that females might be better served in a residential treatment center than in a detention center.

It has been found that many adolescents in the juvenile justice system experience poor and inconsistent parenting, dysfunctional parental behavior, as well as behavior and lifestyle problems (Hoge, Andrews & Leschied, 1995). In recent years, the system has begun to assume more responsibility for adolescents by providing family therapy, mental health treatment, and other services (Binder, 1988). Some adolescents are given the option of completing treatment at a residential treatment center rather than serving time in a detention center.

A residential treatment center has been defined as an out-of-home twenty four hour facility that offers mental health treatment in a variety of ways, often utilizing a multi-disciplinary team to do so. Residential treatment centers frequently make therapeutic use of the living arrangements and group dynamics. Residential treatment differs from psychiatric inpatient units in that they are less restrictive (Burns, Hoagwood & Mzarek, 1999). Residential treatment is used for a small percentage of children and adolescents for whom community based treatment is not effective. It has been suggested that residential treatment can

provide clear and consistent boundaries that families are unwilling or unable to provide (Hair, 2005).

There is a wealth of literature attempting to explore the efficacy of residential treatment. Many studies have shown this to be an effective method of treatment. Research in residential care includes: outcome studies (Curry, 1991); (Hooper, Murphy, Devaney & Hultman, 2000), length of treatment (Hussey & Guo, 2002), character traits correlated with success and failure (Munson & Reeves, 1986; Plapp, 1983), effects of peer influences on treatment (Townsend & Hansen, 1986), family involvement and influence (Pillari, 1992) and different theoretical approaches (Menses & Durrant, 1990; Munson, Klein & Delafield, 1989).

Research on the efficacy of residential treatment for adolescents has been mixed (Hair, 2005). Researchers often have different definitions of what constitutes “effective” treatment (Bates, English & Kouidou-Giles, 1997).

For example, sampling problems are often encountered in residential treatment. Due to the nature of this research, most studies have employed single-sample pre-test, pre-test-post-test or post-test designs only, with no comparison or control group (Wells, 1991). Several methodological difficulties may contribute to the lack of consistent findings.

Most programs do not have enough residents to conduct a valid outcome study. The small samples limit the generalizability and cause researchers to question the validity of the findings. Second, many studies of residential care use instruments without proven reliability or validity or fail to obtain post-

treatment data in a consistent way. The effectiveness of residential treatment also varies depending on the outcome variables examined. If treatment efficacy is measured by future contact with the law or school suspensions it may not be viewed as favorably as a measure of therapist or family's view of treatment, as these two entities have different ways of measuring success (Bates et al., 1997). Third, the timing of data collection can also affect the perceived efficacy of the program. For example, Jenson and Whittaker (1989) found that if data were collected during treatment or immediately following discharge, the results were more favorable than if data were collected at increasing intervals of time after treatment.

Finally, there is no standardized model of residential treatment. This makes outcome research complicated as it is difficult to compare programs using different models of treatment. Furthermore, because there is no standardized model of residential treatment, it is almost impossible to know what aspects of each program led to change. The present study hopes to examine the specific processes of change that lead to progression through the stages of change, specifically for the population of adolescent females.

Despite these methodological difficulties, there are several consistent findings about what contributes to success in residential treatment that seem clear. Residential treatment is more effective when the resident's family is actively involved throughout their treatment (Burns et al, 1999; Stage, 1999). Family involvement has been found to be essential to maintaining emotional and behavioral changes after leaving residential care (Hair, 2005). In one study,



family involvement was the only significant predictor of whether the resident would be discharged successfully from the program (Hussey & Guo, 2002). Another study found that residents with more visits from family members were more likely to be successfully discharged from the program than those whose family members did not visit (Sunseri, 2001). The amount of time spent in residential treatment is important, and longer is not necessarily better (Hussey & Guo, 2002). Many behavior improvements have been noted in the first three to six months of treatment, with no further gains after this time period (Shapiro, Welker & Pierce, 1999).

A further finding is that the symptoms of the resident usually decrease while the resident is actually in treatment. Residential treatment has been associated with a reduction of psychopathology at discharge as well as decreased aggression, high-risk behaviors, depression and psychotic features (Hussey & Guo, 2002). It is more difficult to measure whether these changes are sustained once the resident leaves treatment and transitions back to the family. However, one predictor of greater success after leaving residential treatment is continued treatment and ongoing support (Hooper, Murphy, Devaney & Hultman, 2000). Aftercare services are important in terms of transitioning the resident back to the community and maintaining gains made in treatment (Hooper et al, 2000). Repeated studies have associated continued therapy after discharge with increased functioning (Curry, 1991). There has been a shift in viewing residential treatment as just part of the solution rather than a one-stop cure for troubled adolescents (Hair, 2000).

## Stages of Change

Though researchers have made gains in many areas regarding residential care, there has yet to be an identified process of why and how change occurs. What actually happens during treatment for these adolescents?

Numerous researchers have agreed that further research needs to be done to address this question. For example, Hooper et al. (2000) found that psycho-educational residential treatment could be beneficial to adolescents but found it “unclear what aspects of this residential program influenced these relatively positive outcomes” (p. 497). Oles (1991) studied perceptions of change in adolescents in a residential treatment center. Oles classified residents’ attitudes towards change as either passive or active, and used this assessment as a basis for what kind of aftercare services would be recommended. An active attitude was defined by residents who expressed interest in making changes and took active steps to do so. A passive attitude was defined by residents who did not believe change was necessary and seemed to participate minimally in treatment. Despite the subject matter and emphasis on change, this study offered no insight into the change process itself.

A process of change in psychotherapy has been identified and documented (Prochaska and DiClemente, 1982; Prochaska, DiClemente & Norcross, 1992). This process was originally established studying individuals who were attempting to quit smoking and has been applied to substance abuse treatment and other addictive behaviors. Over time, this process has been generalized to a variety of other domains including psychotherapy and the

counseling process in general (McConaughy, et al., 1983). The change process has been studied in a variety of populations, but the majority seems to be with adults in substance abuse treatment or those trying to quit smoking. There is much less research on women than on men, and even less on adolescent females.

Prochaska and DiClemente (1982) identified five distinct stages of change. The first stage is Pre-Contemplation. In this stage, the person is entering therapy but does not see a problem or have motivation to change. Often people in this stage feel pressure from friends or family to enter treatment. The second stage of change is Contemplation. In this stage the person is beginning to understand that a problem exists or is bothered by some part of himself. The person is seeking more information about his problem but is still not ready to commit to change. The third stage is Decision Making. In this stage the person has committed to making a change and accepted the responsibilities but has not yet begun to make changes. The fourth stage of change is Action, where the person takes active steps to change behavior or environment. In this stage the person has tried to change on his own and been unsuccessful and realizes the need for help. The final stage of change is Maintenance. In this stage the person makes significant changes but is seeking treatment to avoid relapsing. This person has already made much progress from where they started and are working to maintain their positive behaviors.

Studying the stages of change is important for a number of reasons. Research has suggested that therapists often assume clients come into therapy

in the Action stage, ready to make changes. However, research has suggested that many clients are actually still in the Pre-Contemplation stage when they begin treatment (Prochaska & DiClemente, 1982). This is especially true for adolescents, court ordered clients, and others who enter therapy due to outside pressure rather than their own motivation to change. Adolescents generally have less motivation to change because they may not have experienced serious enough consequences to feel change is necessary (Winters, Stinchfield, Opland, Weller & Latimer, 2000).

Different interventions have been found to be more effective when matched with a client's level of change. For example, verbal processes, such as psycho-education and feedback might be more effective in the beginning stages of change, while behavioral interventions could be more effective for clients in the Action and Maintenance stages (McConaughy et al, 1983). By assessing a client's stage of change, therapists are better able to tailor treatment to an individual's level of change, select appropriate interventions, increase motivation and increase the overall efficacy of therapy (Da Silva Cardoso, Chan, Berven & Thomas, 2003). Adolescents in particular may benefit from education regarding the process of change and what challenges they might expect in the different stages. Identifying change as an ongoing process could be helpful in terms of validating the feelings they experience and normalizing their struggles (Hemphill & Howell, 2000).

In summary, though researchers have made gains in many areas regarding residential care, there has yet to be an identified process of why and

how change occurs. Further research needs to be conducted in order to determine what parts of residential treatment are effective for facilitating change among adolescent girls. Rafal (1991, p. 6) noted, “a better understanding of factors associated with success in various forms of substitute family care is needed.” This study aims to fill some of the gaps in understanding effective residential treatment.

### Significance

Juvenile crime has been identified as a serious social problem with significant social and economic costs. In 2002, the Commonwealth of Virginia had an average daily population of 1,139 juveniles in its correctional center. The annual average cost per ward was \$59,403, which does not include the costs of providing education to the inmates, an additional \$18,000 per inmate each year (Department of Juvenile Justice, Richmond VA, Report on Audit for 2002, <http://www.apa.state.va.us/reports/DJJ02.pdf>). For Virginia alone, this is a total of \$88 million per year spent on juvenile justice. Understanding the change process could be vital in terms of decreasing the recidivism rate and increased re-integration into society.

The social costs of juvenile crime are equally alarming. Lost wages, medical expenses, pain, suffering, and loss of life are just a few of these costs (Cohen, 1998).

There is also an immeasurable cost to the victims of juvenile crime. Research has shown that most of the victims of juvenile crime are actually juveniles as well. 65% of victims of juvenile violence were within 5 years of age from their

perpetrator (Synder & Sickmund, 2006). Evidence suggests that being the victim of a crime increases the chances of emotional or behavioral problems in the future. In particular, many victims of crime suffer from both Post Traumatic Stress Disorder (PTSD) and/or Major Depressive Disorder (MDD) (Foa & Riggs, 1995).

### Rationale

Though there is a wealth of literature on the stages of change (McConaughy et al, 1983; Prochaska & DiClemente, 1983), little research has been conducted on adolescent female offenders and how these stages of change apply to this population. This study hopes to discover the process through which these young women change from delinquent/anti-social behaviors to more pro-social behaviors by interviewing the female adolescent offenders in the residential treatment center to which they are court ordered. It is believed that studying the problem in this way, through the use of in depth qualitative interviews, is the next logical step in terms of truly understanding what happens for adolescent girls in residential treatment. Furthermore, the traditional stages of change can be explored with this population and expanded upon to develop a process of change unique to this population.

### Theoretical Framework

The theoretical frameworks of Phenomenology and Grounded Theory will guide this study. In Phenomenology, the phenomenon of interest is studied where it naturally occurs and from the actor's perspective in order to gain understanding of the actor's experience. Truth and understanding is learned

from people's experiences in life. The lived experience of the actor is central to phenomenology, as well as the concept that we are only able to understand an actor by studying him in his world and context (Owen, 1994). In phenomenological research, qualitative methods are often used to transcribe materials, code data into themes, and draw conclusions based on the phenomena revealed by the themes. In the current study, researchers will examine the experiences of adolescent females on probation in a residential treatment center and their experience of change throughout their treatment.

Grounded theory is guided by an interest in process and change, which ultimately leads to development of a theory (Glaser & Strauss, 1967). In grounded theory, there is an emphasis on the importance of language and words in social life, on seeing the link between emerging variables, and creating a story line. Grounded theory was originally developed by Barney Glaser and Anselm Strauss in 1967. One goal of grounded theory is to develop hypotheses based on abstract ideas. Grounded theory is not interested in the "truth," but rather what is occurring from the participant's point of view (LaRossa, 2005). In the current study, grounded theory will be used to describe the process of change for adolescent girls on probation in a residential treatment facility.

### Purpose of the Study

The purpose of the study is to develop a stage of change model for adolescent females on probation in a residential setting. The following research questions will be addressed:

1. What is the process of change for adolescent girls on probation in a residential treatment center?
2. How, if at all, do the traditional stages of change apply to this population?
3. What factors motivate these adolescent girls to progress through these stages of change?



## CHAPTER 2

### Literature Review

This study aims to explore and establish stages of change for the population of adolescent female offenders on probation in a residential treatment center. Therefore this literature review will first review the current literature on residential treatment for adolescent females. This literature review will also address the literature on stages of change and the populations to which they have been applied.

### Effectiveness of Residential Treatment

Marholin, Pliwnis, Harris and Marholin (1975) implemented a behavioral approach at a residential program for adjudicated adolescent females. Through a systematic mobilization of different parts of the community, mainly the school setting, they were able to initiate specific academic and social behavior change.

Participants were 15 pre-delinquent females ranging in age from 12-19 years from a community based residential treatment facility. The average length of stay for residents was between nine and twelve months, with a goal of returning residents to their original home, foster care or independent living. Data were collected through weekly report cards from teachers at the community public school residents attended during the day. This program used a behavioral approach to modify behavior, but no more details as to what this entails were included in the study.

This program was effective in improving the grades of 14 out of 15 girls in one school semester. The group grade point average increased from a D- to a

C+ in less than two months. Tardiness, truancy and absences among residents were reduced during this time. Furthermore, staff noticed a difference in the residents' attitudes toward school. Rather than speaking about teachers, grades and homework in a negative way, girls were observed encouraging each other and giving each other positive attention for higher grades.

There are several limitations regarding this study. First, there was no comparison group. Second, there was no follow-up group to determine if these results were a temporary phenomena or longer lasting. Finally, it was not clear exactly why the weekly report cards were so effective with this group. More research would need to be conducted in order to determine what aspects were instrumental in the academic and behavioral changes that occurred.

Munson and Revers (1986) examined the program effectiveness of a residential treatment center for emotionally disturbed adolescent female offenders as measured by exit personality tests. Adolescent females in residential treatment were given personality tests at discharge and compared with a control group of adolescent females who had not experienced unusual behavior or adjustment problems. The control group was 141 adolescent females from a working class background who attended an all-girls Catholic high school. The treatment group was made up of 30 adolescent females from a treatment center for emotionally disturbed female status offenders, also from working class backgrounds. There was a significant difference between groups on four of the subscales: Value Orientation, Immaturity, Manifest Aggression, and Withdrawal. The treatment group scored higher on several subscales than the

control group, who had not experienced behavior problems in the past. On the Value Orientation subscale, the two older treatment groups scored lower than the controls, indicating they had developed more pro-social attitudes while in treatment. On the Alienation scale, treatment girls scored lower than the control girls, indicating less alienation and more trust in others, particularly authority figures. On the Manifest Aggression scale, treatment girls scored lower, indicating feeling less threatened with experiencing negative or angry emotions. Overall, the oldest group of girls from the treatment group came closest to the personality scores of adolescent females who had never been admitted to residential treatment, suggesting that older adolescents demonstrate greater internalization of the pro-social beliefs emphasized by the treatment center. Limitations include not being able to generalize these results to other treatments centers of participants, as well as the possible bias of obtaining all the control participants from an all-girls Catholic high school, which might not be representative of the general population.

Rafal (1991) studied non-adjudicated adolescent females' adjustment to group home care. In order to make treatment most useful, Rafal identified predictors of adjustment to residential treatment and developed the Adolescent Adjustment Scale (AAS) to measure adjustment to treatment. A retrospective case analysis was utilized to examine 78 former residents of a group home for adolescent girls in Baltimore, Maryland. Three-fourths of the residents were between the ages of 15 and 17 at the time of their admission, and the average length of stay for residents was thirteen and a half months. Rafal examined the

relationship between information known about residents at intake and later adjustment to residential treatment.

This study found that girls who were placed in residential care due to the death of a parent, girls who were older at their time of admission, or had histories of suicidal thoughts adjusted best to residential treatment. On the other hand, girls with a history of runaway behavior, school attendance or academic problems were found to have the most trouble adjusting. When school attendance problems were controlled for, girls older at the time of their placement tended to adjust better than girls who were younger at the time of admission. Problems related to school were the most significant finding in terms of factors predicting adjustment to residential care. Number of previous placements and history of maltreatment were not found to be significant predictors of adjustment in this sample.

Limitations to this study include a lack of baseline data. Without baseline data, it is difficult to notice individual progress, and girls who improve drastically could still be rated as poorly adjusted if they were low functioning to begin with. Second, it would have been helpful to have had a comparison groups at different facilities during the same time frame to see if these findings were specific to this one facility or consistent across residential care. Furthermore, additional research is needed on school issues for this population, and what can be done to address the needs of adolescents in residential care for whom this is a treatment goal. Specifically, it would be useful to determine what factors contribute to

problems with school and what interventions would be most helpful to address these needs.

Hooper, Murphy, Devany, and Hultman (2000) explored outcomes for non-adjudicated male and female adolescents in a residential treatment facility that used a re-education model. Follow-up data were obtained at 6, 12, 18 and 24 months through phone interviews with case managers of the adolescents. The results indicated successful outcomes for 58% of the adolescents. This study also examined characteristics of the successful adolescents and found that a successful treatment group was likely to have more females, be younger, have higher IQ scores, fewer psychiatric diagnoses, and be rated higher by parents or guardians on internalizing behaviors.

One limitation was that results were dependent on the observations of case managers; therefore, this rating is somewhat subjective depending on the case manager and his or her interactions with each resident. Another limitation is the difficulty of tracking ex-residents once they turn eighteen, as they are no longer receiving treatment from youth providers and often difficult to find in terms of gathering follow-up data. Finally, these results are difficult to generalize due to the wide range of differences between treatment centers as well as characteristics of the residents in each center.

Trupin, Stewart, Beach and Boesky (2002) examined the efficacy of a dialectical behavior therapy (DBT) program for incarcerated female juvenile offenders. Participants were 60 adolescent females incarcerated at a Washington State Juvenile Rehabilitation center. Standardized measures were

completed with participants prior to implementing the DBT program, measuring DSM-IV diagnoses and current functioning. Additional information was gathered through staff interview, chart review, and daily behavior logs that were kept for the mental health cottage during the study as well as for the previous year. The youth were given risk assessments at the time of their admission to the facility in order to determine placement and security level, and these were accessed as well as administered again at a 90-day follow-up. During the study, the females in the mental health cottage experienced a significant decrease in behavior problems during the course of the ten-month study. Suicidal acts, class disturbances and aggressive behavior decreased, though not by a significant amount. Researchers offered the explanation of general population youth frequently being transferred to the mental health cottage, therefore keeping these behavior ratings consistently high. Youth in the general population treated with DBT and without any other treatment did not show any significant behavioral differences. One reason for this might have been the absence of suicidal thoughts or self-mutilation in these groups, behaviors that DBT specifically targets. Risk scores did not significantly decrease among the two groups. This could be due to some of the fixed items on the assessment, such as number of prior offenses and previous drug and alcohol use, which limit the possible variance.

One limitation in this study is the difference in training hours provided to the mental health cottage staff as opposed to the general population staff. This difference in training could partly account for why the general population was not

as successful, since general population staff received fewer training hours. The high turnover rate of the mental health unit as well as the fixed items on the risk assessment could also be viewed as limitations in this study.

Outcome evaluation research has been conducted with adolescent boys and girls from the Girls and Boys Town Family Home Program (Larzelere, Daly, Davis, Chmelka & Handwerk, 2004). The participants were 440 discharged youth from the Boys and Girls Town Family Home Program between October 1998 and September 2000. Girls accounted for 38% of the participants, with age at admission varying from 8.6 to 18.6 years. The most frequent reasons for admission to residential care were non-compliance (89%), academic problems (59%), school behavior problems (56%), drug or alcohol usage (53%), verbal aggression (48%), truancy (45%), peer relations (45%), theft (45%), and depression (44%). The average length of stay was 1.8 years. About 59% of the participants were discharged successfully due to completing the program or graduating from high school.

This study used several standardized outcome measures that examined the level of restriction in the current living environment as well as psychopathology and DSM-IV diagnoses. Several non-standardized outcome measures were also used to measure departure success and follow-up functioning.

The results indicated that the Family Home Program was an effective mode of treatment for both boys and girls. The majority of adolescents were discharged to a significantly less restrictive environment following treatment, with

84% of girls returning to the home or living independently. Both boys and girls had fewer DSM-IV diagnoses on the twelve-month follow-up than at intake. In girls, the percentage with a DSM-IV diagnosis decreased from 70% to 24%. In general, treatment was rated as successful, with clinicians viewing girls more favorably than boys in terms of program success. Overall, 87.1% of presenting problems for boys and 89.3% of problems for girls were viewed as improved at discharge.

There were several limitations to this study, the first being that there was no comparison group. Second, there was a 33% attrition rate for the three outcome measures. Finally, a follow-up period longer than three months would be beneficial in order to determine how long improvements made in treatment are maintained.

Connor, Doerfler, Toscano, Volungis and Steingard (2004) studied characteristics of non-adjudicated adolescents and children admitted to a residential treatment center. Participants were 397 boys and girls admitted to a treatment center in New England between 1994 and 2001. Participants were assessed at the time of admission through clinical interviews based on DSM-IV criteria, and measures of psychopathology, hyperactive/impulsive behavior, self-reported substance use, intelligence, aggression, family history, and physical and sexual abuse. Results indicated significant differences between boys and girls on several measures. Girls scored significantly higher on scales, measuring DSM-IV diagnoses of conduct disorder, anxiety and depression. Additionally, girls showed higher rates of internalizing and externalizing behaviors, with higher



overall measures of psychopathology than boys. On measures of aggression, girls scored significantly higher than boys on three subscales of aggressive behavior. Girls scored higher on the Perceived Hostility scale, demonstrating their view of the world as more hostile than boys. There were no significant differences in terms of parental arrest or parental violence, but a parent or caregiver who abused alcohol was more common in girls than in boys.

Regarding out of home placements, there were significant differences between boys and girls in number of prior out-of-home placements, with girls having more out of home placements than boys.

Limitations to this study include the lack of a comparison group, a frequent limitation in research on residential care. Additionally, the sample was obtained from one specific treatment center and results do not generalize to adolescents in other types of centers that serve different populations with other models of treatment.

In contrast, not all research on residential care yield such successful results. As previously discussed, there are many methodological difficulties when conducting research on residential care. Gossett, Lewis, and Barnhardt (1983) conducted an outcome study on boys and girls in a private psychiatric facility. Follow-up interviews were conducted between three and eight years following discharge and participants rated their current level of functioning as “good, fair, or poor.” Overall, 27% rated their functioning as “good,” 42% as “fair,” and 31% as “poor.” Approximately 20% had been re-hospitalized and 20% still

suffered from some form of depression. Of the 102 participants, 13 had experienced psychotic episodes and 3 had committed suicide.

Based on this study and studies like this, Curry (1991, p. 350) concluded, “the results of these studies of hospitalized youths suggest that, although many do improve, some do not, and a small percentage may be expected to have a variety of seriously negative outcomes on long term follow-up.”

In summary, there have been many important contributions to the growing body of literature on adolescent females’ response to residential treatment. The following findings have been researched at length and seem to be fairly well established. Characteristics of girls who enter residential treatment indicate higher levels of anxiety, depression, and aggressive self-directed behavior compared to adolescent boys, as well as higher levels of physical and sexual abuse and parental alcoholism than adolescent boys in treatment. This research suggests that girls must reach a higher level of distress than their male peers to be considered for residential treatment. In some studies, residential treatment has been shown to increase school attendance, grades and pro-social attitudes, as well as decrease symptoms of psychopathology. Many studies seem to agree that older adolescent girls tend to do better in treatment than younger girls.

Yet there are many limitations to these findings. There is frequently an inability to generalize results due to differences between treatment centers, staff, and theoretical models applied. Without knowing exactly what occurs in terms of treatment in different facilities, it is difficult to know what parts of treatment contribute to change. Furthermore, it is difficult to find a true comparison or

control group for many of these studies. It can also be difficult to obtain follow-up information once the residents leave the treatment center or turn 18. In addition, most studies on residential treatment do not involve adjudicated youth. For adjudicated populations, recidivism is not consistently measured. In sum, there is a need for more research explaining why change occurs when girls are admitted to residential treatment, as well as more information on the experience in treatment for this understudied population.

### Stages of Change

DiClemente and Prochaska (1982) first developed the stages of change in adult cigarette smokers, but have since applied and generalized the stages of change to various populations. Cigarette smokers who decided to quit on their own were compared with two structured smoking cessation programs.

Participants were given a questionnaire on their process of change seven weeks after cessation and at a five-month follow-up. Based on the Transtheoretical model of change, six verbal processes and four behavioral processes of change were identified. The verbal processes included feedback, education, corrective emotional experience, dramatic relief, self-liberation, and social liberation. The behavioral processes were counter-conditioning, stimulus control, self-management, and social management. In addition to these verbal and behavior processes, three stages of change were established: Decision to quit, Active change, and Maintenance. These stages were later expanded upon and re-named as Pre-Contemplation, Contemplation, Preparation, Action, and Maintenance (McConaughy et al., 1983). DiClemente and Prochaska found that

verbal processes were critical to making the decision to change, and action processes more important when physically stopping the habit of smoking.

Hemphill and Howell (2000) gave 225 adolescent offenders the Stages of Change scale developed by McConaughy et al. (1983). Participants were 237 consecutive participants to a psychiatric facility during a period of two years. The majority (77.8%) of the participants were male, and ranged in age from 12 to 18 years. Results demonstrate that adolescents received scores comparable to those of adults given the same measure, suggesting that this scale could be used effectively with adolescents as well as adults. Results indicated some differences, including that adolescents typically identify fewer aspects of change than adults, and that they tend to associate making changes with taking action. Adolescent participants' scores on the measures of pre-contemplation and contemplation suggest that they saw these more as one stage than two separate stages. Adolescent participants also reported being less concerned with the possibility of relapse than their adult counterparts.

These results need to be replicated in order to gain further validity, as this was one of the first times the Stages of Change scale was applied to adolescents. The authors also suggested that more research on which interventions were associated with different stages of change could be beneficial to this topic.

Brown, Melchior, Panter, Slaughter, and Huba (2000) studied the steps of change and entry into treatment in women with substance abuse, domestic violence, mental health needs, and high-risk sexual behavior. They designed the

Women's Outreach Model to address the multitude of needs for this group of women. The theory was that a woman's willingness to change would help her decide which kind of treatment program to enter. The model addressed four kinds of change women were seeking: readiness to change a domestic violence situation, readiness to change high-risk sexual behaviors, readiness to change substance abuse behaviors, and readiness to deal with emotional problems.

Participants were 451 women enrolled in a community based outreach program. Almost all (99.3%) were current substance abusers, with 79.8% choosing crack as their drug of choice. The women ranged in age from 15 to 69 years old, with a mean age of 35.7 years old. Participants' readiness to change was assessed using a measure based on the Stages of Change Transtheoretical model that was administered at intake. Participants' referrals to treatment were subsequently tracked to see if they sought any kind of treatment.

Researchers wanted to determine if there was a single factor in each of the four areas that would cause a woman to want to change and found that there was not. They did discover that women were more likely to want to change issues that had immediate harm to themselves or their children. The highest change score was readiness to change a domestic violence situation, followed by readiness to change high-risk sexual behaviors, drug treatment, and emotional problems. The majority of women saw domestic violence as the most immediate threat; therefore, they were most likely to first take steps to change this aspect of their lives.

Results indicated that readiness to change a domestic violence situation and readiness to seek help for substance abuse had a significant effect on entry into a 12-step program, while readiness to change high risk sexual behavior and readiness to seek help for emotional problems did not significantly affect entry into a 12-step program. Drug of choice had a significant effect on entry into a residential treatment center; crack users were six times for likely to enter treatment than non-crack drug users. In general, this study found that women in the Preparation and Action stages were more likely to enter treatment than women in the Pre-Contemplation or Contemplation stages.

This study indicated that women do not have a single factor that causes them to want change, but that they were most likely to address the most immediate threat first. There were several limitations to this study, the first being that this study used a new, non-standardized measure that has not been compared to already established readiness of change measures. Future studies would need to address this issue. Second, this study focused mostly on drug treatment and women's willingness to enter this type of treatment. Further studies are needed to address the additional types of treatment that women need.

In summary, the stages of change were originally established with the population of adult male and female smokers who were trying to quit smoking. The stages of change were later applied to adolescents in substance abuse treatment and results suggested that these measures of change could be applied effectively to adolescents as well as adults. Finally, the stages of change were

applied to adult women and their entry into substance abuse treatment. No single factor was found to cause change in this population, but results suggested that women were more likely to change behaviors that they viewed as the most immediately harmful to themselves or their children. Limitations to this research include the need for further replication, as well as more information on what types of interventions are associated with each stage of change. There is also a need for further research on different populations and issues, as the stages of change have been primarily applied to adults and substance abuse treatment.

## CHAPTER 3

### Method

#### Design of the study

This study used grounded theory and phenomenology approaches to develop a process of change in adolescent females in a residential treatment center. Data were obtained through retrospective individual interviews with residents of a residential treatment center in Northern Virginia. Semi-structured, open-ended questions were asked in order to obtain a rich description of each girl's experience of change.

#### Participants

Participants were 4 residents of a residential treatment program in the Washington D.C. metropolitan area. The program was a community-based group home whose residents were court-ordered to treatment due to delinquent behavior or chronic status offenses. The age range of participants was 15 to 17. The average length of stay was six to eight months. In order to be included in the current study, participants had to have been in the program at least four months. The reason for this was so that participants would be able to make changes and be able to reflect on some of the changes they had made. In the current program, the four month mark is approximately when participants would be on level two of the program. In order to earn level two, participants must be committed to making changes; therefore this seems like a good marker of when participants would be able to contemplate changes they had made so far.



The program of interest for this study was a highly structured setting that places an emphasis on personal responsibility, independence, self control and self confidence in the hopes of changing the behavior for which the girls were originally court ordered. The ultimate goal was for residents to return to their homes and become productive members of their communities. The program practiced behavior modification through the use of a level system, where residents gained more privileges as they progressed through different levels in the program. Earning levels was based on earning a certain number of points, and residents gained points for positive behavior or lost points for negative behavior. Additionally, the girls participated in individual, family, and group counseling in order to achieve individualized treatment goals.

### Procedures

All participants and their parents or legal guardians were told the nature and purpose of the research prior to the study, that their participation was voluntary, that their responses would remain anonymous, and that they could withdraw at any time. Confidentiality was explained in detail to participants and legal guardians. Participants were informed of any possible risks of the study. All interviews were audio recorded with the participant's and parent or legal guardian's permission using a tape recorder. Participants were not compensated for their involvement. All interviews lasted between 30 and 60 minutes and interviews took place in therapy rooms at the treatment center. Each participant was interviewed only once, and interview times were arranged between the researcher and participant.

The interview questions were developed based loosely on the traditional stages of change, but were intentionally left somewhat open in order to leave space for other indicators.

Instruments:

Interview Protocol

Pre-Contemplation:

- How did you end up at this program?
- How did you view your actions at the time?
- What happened as a result of your actions and behavior?
- Did you have any thoughts or desire to change your behavior before coming to this program? If so, what were they?

Contemplation:

- Had you ever been interested in making changes but were not sure how to go about doing this?
- Tell me about what it was like adjusting to this program.

Preparation:

- How did you begin to change your attitudes and behaviors?

Action:

- Tell me how your family relationships changed throughout treatment?
- Tell me about your relationships with staff throughout your treatment? How did these relationships affect your treatment?
- How did relationships with peers affect your treatment?
- What parts of the program were most helpful to you in making changes?

-How was your experience in individual and group therapy?

-Do you think it was important to share your past in order to make changes and move forward? If so, why?

-Did the rewards or consequences you received in the program influence your willingness, ability, or desire to change? How?

Relapse:

-Tell me about any struggles or bumps along the road you experienced. How did you rebound after these experiences?

Maintenance:

-What has been the biggest change you have noticed in yourself?

-What has been the biggest change other people have noticed in you? (Family, friends, teachers, probation officer)

-Some girls I have talked to have had a hard time getting their parents or probation officers to see the changes they had made. What was your experience with this?

-How has your description of yourself changed since beginning the program?

-What has helped you maintain the positive changes you have made?

### Analyses

Interviews were audio recorded, and then transcribed. Transcription occurred after all interviews were complete. Data were analyzed through the use of open and axial coding. Data were analyzed first by a process of open coding. Each individual interview transcript was broken down into basic themes, phrases, and categories. In axial coding, themes developed in open coding were

developed in more detail and examined to determine their relationship to other themes. Ultimately, a theory of change was developed based on the relationship observed among these themes. Data were also analyzed through the use of reading, writing, rewriting, and reflection in order to translate the interviews and data collected into a meaningful story of the experience for the participant (Richards & Morse, 2007). In addition, an advisor also read and coded the data in order to authenticate and strengthen the results of this writer.

## CHAPTER IV: RESULTS

In this study I explored the experiences of adolescent females on probation in a residential treatment center. The goal was to explore the process of change for this population. I conducted four qualitative interviews. All participants were females, ranging in age from 15 to 17. Participants were on probation for a variety of reasons, ranging from truancy to armed robbery, and all participants had violated their probation. All were court ordered to attend the residential treatment program. Throughout the coding process, data were viewed through the lens of two theoretical frameworks: phenomenology and grounded theory. Many interesting patterns and themes emerged from the data, helping me to identify a theory of change for this population. In the following chapter I will present summaries of each interview, followed by an analysis of the data guided by the theories of Grounded Theory and Phenomenology.

### Interview One: Summary

Rosario is a fifteen year old Hispanic female, on probation for truancy, who lives with her mother in the D.C. metro area. She had been in residential placements prior to coming to her current placement and had no desire to change her behavior when she entered the program. At the time of her interview, Rosario had been in the program for five months.

Rosario explained that she first made changes because of the consequences she would receive if she did not. The one aspect of her life that she did want to change was her relationship with her mother. She reported not having a difficult time adjusting to the program due to having been in other

programs before. Throughout her interview Rosario presented as very guarded, describing feeling comfortable only with certain staff and having a very difficult time opening up to other participants in the program. Of all four participants, Rosario seemed to have the most difficult time accepting the possibility of change, but there were a few times when she was able to express hope that change was possible. She identified the consequences in the program as helpful in maintaining her behavior, but did not find the rewards to be an incentive. Some of the biggest changes she noticed in herself included an improved attitude and more positive relationships with authority figures both inside and outside of the program. One struggle for Rosario was her feeling that no one noticed when she did something positive, they only noticed her negative behavior, which she reported made her feel like giving up.

#### Interview Two: Summary

Penelope is a fifteen year old Caucasian female. She was on probation for truancy and violated her probation by not obeying her curfew and smoking marijuana. She lives with her mom and brother in the D.C. metro area. At the time of her interview, Penelope had been in the program for six months.

Penelope differed from other participants in that her process of change seemed much more internal, as she seemed to struggle more with her own thoughts and feelings rather than program rules or interactions with staff or peers. She displayed fewer behavioral issues than the other participants, but seemed to share their same level of distress. She had few problems adhering to the behavior management system in the program and seemed to get along with

adults outside of her family reasonably well. She reported wanting to change her behavior prior to coming to the program, particularly in regard to her drug and alcohol use, but had a difficult time because she was used to behaving in that way. Penelope reported having a difficult time adjusting to the rules and structure of the program, as this was not something she was used to at home, but again this seemed to be primarily an internal struggle. Penelope reported learning about herself and gaining insight into her actions as most helpful in terms of making changes. She reported her relationships with staff as helpful in allowing her to trust and open up. She reported both consequences and rewards as motivation for positive behavior. Penelope reported feeling more mature as a result of treatment, as well as happier and able to think more clearly. A major motivation for Penelope while in treatment was her grandmother, to whom she was close and who passed away prior to Penelope entering the program.

### Interview Three: Summary

Trudy is a sixteen year old Hispanic female. She was on probation for repeated running away from home. She lives in the D.C. metro area with her grandmother, to whom she refers as her mom. At the time of her interview, Trudy had been in the program for eight months.

Trudy had a very difficult time adjusting to the program in terms of being able to follow rules, control her anger, and get along with the other residents. Of the four interviews, Trudy's was the shortest and offered fewer details about how she was able to make changes. She reported feeling very ambivalent about change, sometimes wanting change very much and sometimes not wanting to

change at all. The one part of her life she clearly wanted to change was her relationship with her mom, but reported that she had given up on this ever changing. Trudy reported significant anger problems at the beginning of the program, and that her anger prevented her from being able to make changes at first. In particular, she often took out her anger on her fellow peers and staff. She was able to identify that focusing on her anger was easier for her than focusing on her own issues. Like Rosario, she had a very difficult time opening up in groups and being able to trust peers in any capacity. Trudy reported feeling like the biggest changes she noticed in herself were less anger and a more positive attitude.

#### Interview Four: Summary

Katrina is a seventeen year old Hispanic female. At the time of her interview, Katrina had been in the program for four months. Prior to coming to the program, Katrina was heavily gang involved and was on probation for armed robbery and use of a firearm. Prior to coming to the program, Katrina lived with her mom and brother in the D.C. metro area. Of all the interviews, Katrina's was the most rich in detail. Katrina reported legal consequences for her action but very few consequences from her parents. She reported having some thoughts about decreasing her drug use or improving her grades prior to coming to the program, but that she was never able to follow through. She reported the consequences she received in the program as being very helpful to initiating change. Katrina reported an extremely conflictual relationship with staff in the beginning of her stay. She reported that this changed as she was able to get to



know certain staff and learned more positive ways to interact with authority figures. She also reported conflictual relationships with peers at first, but was able to move past this by focusing on her treatment and taking on a leadership role in the group. One part of the program that Katrina mentioned as being most helpful for her was her family therapy. While other participants mentioned improved family relationships, Katrina was the only participant who talked in detail about her experience in family therapy. Also helpful for Katrina was developing insight into her own process. She described taking the time to think back about a particular situation and figure out what it was that had caused her to feel a certain way. Also important to Katrina seemed to be the positive attention she received in the program for doing things well. She reported that it was the first time she had ever been rewarded for doing something positive, as opposed to the gang where she was always rewarded for negative and criminal behavior. The biggest changes Katrina reported noticing in herself were less anger and a more positive perspective on life and her own future.

### Grounded Theory and the Process of Change

Grounded theory is guided by an interest in process and change, which ultimately leads to development of a theory. In grounded theory, there is an emphasis on the importance of language and words in social life, on seeing the link between emerging variables, and creating a story line.

The following process of change was developed in the current study.

1. Enter program not wanting to change, feeling like people do not care about them and have given up on them already based on past experiences.

As previously mentioned, participants entered the program because they were court ordered, and at this time participants described not wanting to change their behaviors. Katrina, Penelope, and Trudy had described trying to change some parts of their behavior in the past, but had been unable to do so, due to being in the habit of their behaviors and not having enough support to maintain the changes.

All participants seemed to have lost hope that they would be able to change or that their families would be able to change. They seemed resigned to the fact that they would always be in trouble and did not believe that going to a program would change this. Rosario demonstrates this absence of hope when asked about what part of the program is helpful:

I don't know, cause I don't think in life nothing, not a program, not a facility, not a residential, not...whatever can make anybody change.

Katrina also expresses similar feelings when she shares her thoughts on change prior to entering the program:

I'm hot headed, I have a lot of anger with me, I like smoking weed, uh, I gang bang, and no matter what people tell me, I don't think nobody can change that...Um, I hate snitches

Others, like Trudy, seemed to have doubts about their family's abilities to change. Trudy reflects on her feelings when she first came to the program:

The only thing that I wanted to be different was my relationship with my mom, but I had given up on that ever changing.

Participants reported feeling like their families had given up on them because of all the trouble they had been in. Other participants had been in so many arguments with their family members, both verbal and physical, that beginning to repair these relationships might have felt overwhelming.

2. Initially complied with program rules to avoid consequences.

Participants described beginning to comply with program rules because they wanted to avoid consequences, or were tired of getting consequences and losing privileges in the program. It seemed that once they began following program rules, there was some “buy in” that the program might be helpful in some ways. Participants also seemed to enjoy the rewards they received when they followed program rules.

Participants reported that the consequences and rewards they received in the program were instrumental in helping them to make changes. The program operates on a behavior management system, where residents need to earn a certain number of points each week in order to be successful. A typical consequence might be a loss of points, referred to in the program as “getting negatives,” a loss of privileges such as the phone or television, or loss of a home visit. Typical rewards might include earning additional positive points, being able to go on a special outing, such as the movies or bowling, earning money or gift cards, or additional time on a home visit. As I previously mentioned, many

participants identified initially complying with program rules as a way of avoiding negative consequences. Rosario explained it in the following way:

I mean, cause here you have to listen or else there's consequences. Like here it's your decision whether you want to listen or not but if not then you take the consequences...I guess after the first time, the first consequence, it's like you don't wanna do it again.

It also seemed helpful to Rosario in particular that participants did have a choice about whether they wanted to follow rules or not. It appeared that having some control over her decision was helpful to her. As she said, participants have that choice but also know that there will be consequences if they choose not to comply with rules. For Rosario, the knowledge of potential consequences helped her to make positive decisions.

In terms of rewards, Rosario was the only participant who did not view these as helpful or a motivation. It seemed that she viewed finishing the program as her major motivation, rather than any rewards she might receive along the way:

I see it as being so long here that I don't really know if [rewards are] my motivation, cause it's really not, like I see it, if I did something wrong, like doing time, I wouldn't mind doing time. You don't get to go out, you're just there, but here we go home every weekend. I don't know, sometimes it makes me think, oh, I'm never gonna get out of here, it's so long. Cause you're going home every weekend, getting rewarded with stuff. Honestly, it's like in JDC or Less Secure you're just in there doing your time and

then boom, you're out. They kinda don't...I mean to me, rewards don't mean as much. I just rather do straight up my time and be done with it.

Her response to this question seems interesting in a number of ways. First of all, she compares the program to being in Juvenile Detention and indicates that she would rather be in Detention than in the current program. It makes one wonder how she has been treated in the past, and whether she feels worthy of the care and support she receives in the program. For many participants, the program is the most stable environment they have ever lived in, and this may cause some participants to feel uneasy, as it is something completely foreign to them. I also believe that this demonstrates the black and white thinking that many of the residents display. In this type of distorted thought, people see situations in extremes, with no middle ground. Therefore it makes sense that Rosario would be confused by the treatment program that is supposed to be a consequence for her actions, but that is also helpful and supportive.

Both Trudy and Penelope identified consequences and rewards as helpful in moving forward and motivating them. Trudy explained:

Uh, getting negatives, stuff like that helped me. In order to go to, like, a Friday night activity I gotta work hard for it, so that helped me keep my mind straight and then the negatives would also help me cause they also helped me keep my mind straight and they would keep me from doing bad things, so yeah, those things helped me a lot.

It seemed that for her, having a goal in mind such as a Friday night activity was a motivation for her to stay positive and work hard. She also implies that she is

able to enjoy a reward more if she knows that she worked hard to get it, rather than it just being handed to her.

3. Got to know staff and developed positive relationships.

Participants initially reported some difficulty getting along with staff members. It seemed that as time went on, they were able to discover which staff members they felt most comfortable with, and were able to develop relationships with these staff members. They, in turn, had experiences with these staff members that they were able to label as positive.

Relationships with staff seemed crucial to the change process for participants. The majority of participants entered the program with a history of unstable and conflictual relationships with adults. All participants had been victimized or abused in some way by adults in their lives who were supposed to take care of them. All participants reported strained or almost nonexistent relationships with their parents or guardian. Katrina, Rosario, and Trudy felt like their families had given up on them or stopped caring what happened to them. All participants could identify situations when they had not felt supported by their caretakers. Due to their past experiences, three out of the four participants interviewed described having a difficult time getting along with staff at first. Katrina describes her initial reaction to staff in the following quote:

...at first....[laughs]....it was just like F you and F you and blank blank and this and that and man, forget ya'll, I ain't even listening to ya'll and this stuff and that...

Katrina described being completely closed off to any kind of feedback from staff. Katrina reported a history of being seen only as a gang member and discriminated against because of her race. She had a difficult time trusting anybody in an authority position. Katrina reported that she first began listening to what staff had to say because she was tired of receiving consequences. She describes what happened next for her:

After awhile I started getting to know staff that it's easier to talk to and then after that I learned to...even like for me, I don't care if you staff or resident or not, like, I'll still confront you if I have a problem and stuff like that, and at first that went wrong but then I learned to actually confront in like a positive way, you know? And then after that everything was straight with staff. Um, I think they helped a lot, cause I started getting to know those that I can easier talk to and it helped me to express myself more.

It seems that after getting to know staff, she felt comfortable enough to try to interact with them, and when she saw that her style was not effective, she adapted and learned a style of interacting that was effective.

Rosario and Trudy both described similar processes of having a difficult time getting along with staff initially, but over time being able to accept feedback and begin to trust. Rosario seemed to do this by identifying one or two staff that she was able to connect with and very slowly forming relationships with these staff. Her relationships with other staff remained fairly undeveloped and she seemed to remain cautious around these staff members. Rosario also differed from other participants in that she had experienced previous therapy and

treatment programs, and largely viewed these as negative experiences. Perhaps because of this, she seemed more wary of the therapeutic process than other participants, and questioned how genuine staff members were being with her in session. This is illustrated in the following quote:

I mainly just talk with the ones I feel comfortable talking to. Yeah. Because, um, I don't know, I guess they understand, like the only staff I talk to are...just they actually, like they understand, they're not just saying "oh yeah" or "oh"...or reading things out of books...like, "So how does that make you feel?" Or, "So what happens if this this and that..." Like trying to...like actually understanding.

Trudy seemed to have more tumultuous relationships with staff throughout her time in the program. She described having "ups and downs" with staff, but that she was able to improve on this with time. Trudy described realizing that she was expressing anger at staff rather than expressing anger about her family and past, and was able to focus on her treatment.

#### 4. Felt cared about and supported by staff members.

Participants described feeling cared about and supported in their relationships with staff members. A major part of feeling cared about and supported was reflected in their individual and family counseling sessions, as well as their weekly treatment goals. They described their counseling sessions as a place where they were able to talk about anything that was bothering them and where they could get honest feedback. It meant a lot to participants that



there were staff members willing and emotionally available to listen to them and their past experiences.

A process that several participants described was starting out slowly with staff members and then opening up and sharing more as they felt more comfortable. Participants described feeling more open in these relationships, and being able to trust staff members. One theory could be that by developing one healthy relationship, they were able to use this as a role model for what a healthy relationship looks like and apply it to other relationships in their lives.

There were several different forms in which participants and staff members spent time together. First, the program mandated individual sessions, family sessions, and group counseling sessions. They also spent time during less structured activities such as meals, chores, and any free time that the participants had. As participants are always monitored by staff, there is a lot of informal time that staff and participants spend together throughout the day. It seemed that both the formal counseling sessions and the less structured free time were both important in terms of developing relationships between participants and staff.

As previously mentioned, participants felt supported by staff members in their family counseling sessions and the efforts they made to change their family relationships.

Participants in the program had weekly sessions with an assigned primary counselor. During these sessions they worked on their treatment goals and were able to discuss past issues and their current progress in the program. The

majority of participants identified their individual counseling sessions as very important to them. They reported that it helped them bring up issues that were bothering them, brainstorm for solutions, and express themselves. Some participants described feeling more relaxed after being able to express feelings they had not shared before or been able to express. An example of this is illustrated in the following quote from Rosario:

Like for me, like I bring things up, like whenever I have a goal I can talk about it there. So we bring up issues or we talk about issues like how I think about something to make it better or do something else in like a different way to see if it will change.

Another common theme that showed up in the interviews was the feeling of “a weight off their shoulders,” or feeling relieved to be able to talk about their problems with someone they felt understood them. Many participants reported never having been able to open up the way that they were able to in their individual sessions. This is evidenced in a quote from Katrina’s interview:

In ICs, like individual counseling, I guess it was helpful because I didn’t talk about my problems before and now I’m starting to and it’s getting easier for me and it’s like, again, like a weight off my shoulders.

Each week, participants are assigned approximately four treatment goals which they are required to complete. These might include writing activities, psycho-education packets, artistic activities, group activities, or out of the program assignments, such as talking to a family member about a particular topic or applying for a job. Initially, a participant’s individual counselor assigns them

their goals; as they became more advanced in the program participants are required to develop some or all of their goals and have these approved by their counselor.

Participants reported that they found their goals helpful in being able to express themselves and work on specific treatment areas. Trudy reported her goals as being the most important part of the program for her in terms of helping her to make changes. Similarly, Katrina reported that goals helped her to address her impulsivity and feel more relaxed, as illustrated by the following quote from her interview:

And for the goals? I think we just picked the right goals and the right stuff, like being mindful and I'm actually like thinking before I act and...uh, I was really impulsive back...back before and before I used to be like, Nah, just blow it off, and Nah, you know? But now, I'm just...I don't know, I feel more chill.

In particular Katrina mentioned the practice of mindfulness, which was something she expressed interest in. Katrina and her counselor were able to come up with treatment goals in which she was able to apply the practice of mindfulness to help her accomplish some of her short term objectives in the program. What also seemed important about this for Katrina was that she was able to ask for something and her counselor was able to respond to her in a positive way. It seems that being able to collaborate with her counselor on goals was an important aspect for Katrina.

All participants and their parent or guardian are required to participate in family counseling once a week. In the family sessions, participants and their parents work on exploring family history, roles, dynamics, and patterns that have contributed to the participant's current treatment issues. Many of the families involved in the program have a history of verbal and physical aggression, as well as unhealthy methods of communication. Often times there were family members that had not been involved that re-integrated with the participant and their family over the course of treatment.

Katrina reported family therapy as the most important part of the program for her. She reported that she barely spoke to her parents before coming to the program, unable to express her feelings or thoughts to them. Through family therapy, Katrina and her parents were able to express their feelings and apologize for past actions. In addition, Katrina presented with significant anger management problems at the beginning of the program, despite having been to previous therapy and anger management classes. Through family counseling she was able to learn more about the history of anger in her family and how the majority of her anger was a result of how she had been treated in her family.

This is evident in the following quote from her interview:

My FCs helped me cause, in here and stuff like that we started talking and like before I didn't talk to my parents and I found out that my anger and all the anger that I used to have and why when I went to anger management and all that it never helped, cause it was all from my family and we never did anything about my family before and getting to know why I'm angry

and my parents actually talking and us actually talking about our issues and stuff made me less of an angry person, you know? And I'm not oh so stressed anymore, so it's kind of like a weight off your shoulders.

It seemed that family therapy was helpful in allowing both participants and their parents gain a greater understanding of each other. Because of this understanding, it could be that participants were able to see the past differently and begin to understand why their parents might have made the decisions that they did. Having a family counselor seemed important in allowing family members to feel safe talking about topics that had previously been off-limits or dangerous to discuss in the past. For other participants, family therapy was a way to begin with many past issues that might have seemed overwhelming without some kind of support. Though the most common change participants wanted was improved relationships with their family, many reported having given up on this due to years of fighting and family dysfunction.

5. Increased ability to lower defenses, hear feedback, and begin to trust.

As participants developed relationships with staff, they seemed more comfortable and willing to open up about topics they had not previously discussed. Their increased trust seems most strongly illustrated by their willingness to talk about past issues with staff.

Many, if not all, of the participants had a history of some kind of traumatic event in their life. There was a theme in the interviews of keeping everything "balled up" inside and not talking about what had happened to them or what was bothering them. Many had tried to forget what had happened in the past by

never talking about it. Others believed that there was no use in talking about the past because it would only make them feel worse, as there is no way of changing the past.

Rosario seemed to have the most difficulty with the idea of talking about her past. In her interview she acknowledges that this is what therapists have told her will be helpful, but it seems it has never been helpful to her. Again, Rosario presents as wary of therapists and distrustful of the therapeutic process:

Do I think it's important to share about my past? Yes and no, cause the way counselors see it, they say Oh, if you talk about your past it's gonna help you, like move on or deal with it in a better way but I don't see it like that. I think yeah, it's gonna get brought up, but I don't think it can change the way you see it or the way it happened, because it happened the way it happened and that's not gonna change and you can't erase the past so I don't know, like in a way...I don't know.

Penelope also seemed to have a somewhat mixed view on talking about the past. She did identify it as helpful in that it reminded her of the way that she was feeling at that time, and made her want to take steps not to end up in the same situation with the same bad feelings. In the middle of her response, though, she pauses and says "It's just that...I don't like the past." She then goes on to say again that talking about it is helpful because she had always kept everything inside and never talked about the past with anybody. She described being able to open up and talk about it as a good feeling, which is how she knows that talking about the past is important in order to move forward. It is interesting that

in the middle her response she does have a moment of hesitation, almost as if just describing the process of talking about the past was very difficult for her. It would be interesting to know what memories came up for her even during that short time, and more about what prompted her to stop and make that statement.

Similar to Penelope, Katrina describes talking about the past as a way to unburden herself and let out some of the emotions that have accumulated around past events. In the following quote she describes past events as something that can weigh a person down, but that talking about it provides relief:

In a way, yeah, cause if you just leave things in the past it just stays there...I think it's good, the only thing I could think about it being bad is you might get upset and stuff...but after you talk about it once you talk twice and it just gets out and then you know...stuff builds up inside of you and you just gotta let it out.

It is interesting though that she begins with the qualifier of “in a way,” and also takes time to point out that there can be negative effects of talking about the past. It seems that she has been able to overcome this by continuing to talk about the events until she is able to fully express her feelings about them, which seems to allow her to think about that event in a new or different way.

6. Borrowing external optimism: Received positive feedback about what they were doing well, giving them hope that they could change.

One aspect of the program that seemed very important to participants was hearing about what they were doing well and feeling encouraged to continue this behavior. It seemed that their positive experiences in the program and at school

provided them with hope that they would be able to change their lives. Many were able to think about their futures in a hopeful way, something that they had never been able to do in the past.

Participants reported feeling hopeful when changes they made were recognized by staff, probation officers and their families, but frustrated when they felt like the changes they were making were not being acknowledged. Rosario described feeling that the good things she did were never recognized, which made her feel hopeless about changing:

Um, I don't really know, because to me...like every time there's something bad to be brought up there is. My mom, she's never encouraged me, or my p.o., for the good things that I do, they always notice the bad things. I could do like a whole rack of good things, but they never notice it and they never care, they only see the bad things, so that's why when something good happens I don't even bother, so it's like whatever to me.

According to Rosario, her mom and probation officer only concentrated on her negative experiences and seemed to ignore or not notice her positive choices. One obstacle participants seemed to face was getting stuck in this role of "the bad girl." People in their lives seemed to expect them to make bad decisions, so that this became the only thing that both their families and the girls themselves could see. Rosario seemed to have the impression that no one would notice or care if she made good decisions; therefore she stopped putting any effort into doing this.



Penelope seemed have a similar experience with her mother not seeing the changes she had made. She reports:

Um, it was, I think, my mom didn't really see me changing my attitude, but um, I don't know, I think I've changed and she's finally seen that I've changed.

Penelope describes having a difficult time getting her mother to recognize the changes she had made, specifically her improved attitude. It seems that part of Penelope's motivation to keep going is her own knowledge that she has made changes. At the end of the quote she says that her mother has seen that she has changed, but her statement seems to lack conviction, and she does not elaborate any more on what her mom has noticed. It could be that she does not want to face the fact that maybe her mom has not noticed as much as Penelope would have liked her to. Another possibility could be that because Penelope seemed more internally motivated, she was content knowing she was making the right decisions, and did not need as much reinforcement from other people. Either way, it seems that Penelope is having a positive experience with her new behavior. She says:

...and like it made me want to not go back, cause not getting in trouble is like a better feeling for me than getting in trouble and getting locked up.

So whether the recognition comes from her mother, internally, or another source, something seems to have changed for Penelope such that she enjoys not being in trouble more than the experiences she had of getting in trouble in the past.

Katrina also experienced difficulty getting people to recognize her changes. She described feeling like adults viewed her as a “gang banger” long after she was not involved with the gang anymore and moving forward in the program. She talks about this experience in the following quote:

Yeah, it was hard, cause it was like the same thing I said, [staff] only saw one picture of me and you can tell that they did and stuff like that...I always tried to say it but they'd beat around the bush and say, “Nah,” you know, but I just had to go to more staff that'd be real to me. I just had to be out there more, and I had to show more of what they're expecting from me, and um, I just...You gotta make a history of, like, expectations. You can't just be good one day and mess up the next day, you gotta do it repeatedly and repeat and repeat, you know, to actually build it.

Katrina differed from Rosario in that rather than giving up, she took additional steps in order to make sure that others recognized her changes. She described talking to some staff that she felt were not genuine with her about their opinions, but instead of giving up she sought out additional staff that she felt were truthful and that would give her honest and helpful feedback. In addition, she seemed to be able to see the situation from an outside point of view. Katrina was able to recognize that although she was making changes, it would take time for others to see these, and that she would need to continue displaying positive behavior over time.

The following quote illustrates why it is so important to Katrina that others recognize her changes:

And for the rewards...well cause it was kinda like the first time...nobody had ever rewarded me for doing something right...stuff like, yeah, I might go jump somebody and they'd be like, oh good job, but that's it. But here it's like, good job for other stuff so it feels better, it feels good."

She is able to articulate exactly how important rewards really are for some of these participants. Katrina reflects on her experiences in the gang as the only time she had ever been rewarded, and this was almost always for something illegal or violent. Katrina is unique in that her ability to re-apply skills that made her successful in the gang to become successful in the program. Skills such as strong leadership, determination, organization and intelligence helped Katrina succeed in the program. It seemed to Katrina that more than any of the physical rewards (activities, money, food), the positive feedback and attention she would get for her positive behavior served as a motivator.

According to Katrina, the rewards and praise she received in the program was the first time in her life that she had been rewarded for something positive. Katrina seemed to thrive with the positive attention she received from her parents, staff, and her probation officer. This positive attention helped Katrina feel better about herself and more confident as well:

My P.O. noticed a lot...but now she's like, "You're doing real good" and stuff like that, like that I'm more positive. My family, I guess, they notice that I'm changing, too, and I haven't really talked to friends like that, and these staff, mainly the ones that I talk to the most, they notice that, too...I guess they say I'm more confident about myself.

Trudy also talked about the positive changes her mom, friends and probation officer had noticed in her:

Uh, my mom, what she's noticed is probably my anger and the way I respond to things...yeah. That's what she has seen that has changed a lot. I mean, my friends say I'm more quiet, I'm not as loud as I used to be. My P.O., she sees everything, attitude, more mature, that I understand things more.

Again, it seemed very important to Trudy that people important to her had noticed and recognized the changes she had made. Anger was a major treatment area for Trudy, as well as her relationship with her mom, so to have her mom notice that her anger management had improved was a significant achievement for Trudy. Like Katrina, her probation officer's observations seemed meaningful to Trudy, as she described her probation officer "seeing everything" that she had changed.

7. Open to possibility of change in themselves and more optimistic view of the future.

It seemed that by setting and accomplishing goals, participants were able to believe in themselves more, feeling more positive about the possibility of continuing to change their lives. One helpful aspect was noticing changes they had already been able to make in themselves, such as a more positive attitude, improved relationships with their families, less anger, and more insight into their own process. The combination of observing these changes and feeling more

supported by staff and their families seemed to give them hope that they would continue to be successful in the future.

As participants spent more time in the program they seemed to grow more hopeful. One of the biggest indications of this was increased talk about their futures and a more optimistic tone when talking about their futures. This was particularly noticeable in Katrina's interview. Katrina reports that her success in school while in the program served as a major motivation for her. In the following quote, Katrina's words are very hopeful:

But, um, if I can get used to this, maybe I can finish high school when I get out, cause I wasn't planning to do that before and that's like a motivation. And before I was like, Oh, now I have a record and I'm not gonna be able to get a job easily, but, you know; now I'm putting a little bit of, like, different options out there."

Katrina seems proud of her accomplishments in school, which has led her to believe that she can finish high school. In addition to having hope for her education, Katrina has more hope for her future in general. As she says, in the past she seemed to give up hope on finding a job because of her record, but due to her experiences in school and the program, she truly believes she has more options in life. It seems that this hope provides strong motivation for Katrina to continue doing well in school and staying out of trouble.

Rosario, who earlier said she did not believe a program can change anyone, also expressed hope, but in a different way than Katrina. When she was asked about the importance of talking about the past, Rosario described how she

does not think talking about the past is very helpful because there is no way to change what happened. Yet immediately after stating this, she makes the following statement:

I guess right now I'm gonna try something new with Ms. Susan called EMDR and I'm gonna see how that goes but really I don't know if it's gonna *change* change things...

Despite everything she has been saying, Rosario demonstrates the hope she has in several ways. First, she was willing to try a new method of treatment, suggesting Rosario's hope that it might work. She also mentioned this in the part of the interview that addressed changing the past. Rosario does add a disclaimer about not being sure the new intervention will work. Again, Rosario seems cautious to express hope, perhaps because of past experiences where she was disappointed.

## CHAPTER V: DISCUSSION

### Introduction

The original purpose of this study was to develop a process of change theory for adolescent girls on probation in a residential setting. The results, which were discussed in detail in the previous chapter, illuminated specific aspects of the treatment program that were most helpful to the participants. By analyzing these data, a specific process of change was developed for this unique population. The following chapter will summarize the findings and compare them to existing research on residential treatment and stages of change. It will also explore the clinical implications and limitations of this study, and offer suggestions for future research.

### Process of change in the current study

The following process of change was developed for the current study through the use of grounded theory:

1. Enter program not wanting to change, feeling like people do not care about them and have given up on them already based on past experiences.
2. Initially complied with program rules to avoid consequences.
3. Got to know staff and developed positive relationships.
4. Felt cared about and supported by staff members.
5. Borrowed external optimism: Received positive feedback about what they were doing well, giving them hope that they could change.
6. Increased ability to lower defenses, hear feedback, and begin to trust.

7. Open to possibility of change in themselves and more optimistic view of the future.

Through examining the data and developing themes in the interviews, a process of change for these participants was developed. Participants described initially conforming to program rules in order to avoid consequences or because they were tired of getting consequences. As their needs were met in the program, they began to get to know staff and develop positive relationships with certain staff members. Due to these positive relationships, they were able to be more open and express themselves through their weekly treatment goals, individual and family counseling sessions. Often, this was a gradual process of sharing a little about themselves and determining if staff members were trustworthy. Once they established that they could trust staff, they were able to open up even more and begin to express their emotions. Because of increased trust with staff they felt comfortable talking about past issues, which many viewed as helpful in terms of making changes and being able to move forward. One struggle participants encountered was getting their parents or other adults to notice the positive changes they had made. Once they achieved this recognition, participants were very motivated to maintain these changes and continue receiving positive attention. As a result of their treatment work and the positive changes they were able to make, participants expressed more hope for their futures, as well as a more positive perspective on themselves and their lives.

#### Comparison to previous studies of change



In terms of comparison to previous theories of change, there are both similarities and differences. The theory in the current study is more detailed than Prochaska and DiClemente's (1982) theory of change, which is more general. It is also specific to one treatment center based on responses from four participants, whereas Prochaska and DoClemente's (1982) theory can be much more widely applied. There seemed to be many similarities between the traditional stages of change and the stages of change developed in the current study. Both stages are cyclical, rather than linear, where people may go through the same stages more than once at different times during their overall change process. Participants in the current study seemed to experience many emotions at once throughout their change process. They described a deep desire to change but a lack of knowledge about how to do it. They also described an inability to immediately sustain the changes, reporting a process of making positive changes and then slipping back to familiar patterns of behavior. One noticeable difference between the process of change in the current study and the traditional model of change is the importance of relationships. Participants in the current study reported relationships with staff and their families as very important in terms of making changes. It seems the attachment they were able to establish were a significant factor in change, whereas this element is absent from Prochaska and DiClemente's model of change.

[Links to Previous Research](#)

In comparing the current study to previous research, there were many common ideas as well as differences. These similarities and differences are discussed below.

Hemphill and Howell (2000) gave 225 male and female adolescent offenders the Stages of Change scale developed by McConaughy et al. (1983). Results indicated that adolescents identify fewer aspects of change than adults, and that they tend to associate making changes with taking action. Participants' scores on the measures of pre-contemplation and contemplation suggest that they saw these more as one stage than two separate stages; whereas the action stage was clearly viewed as distinct by the adolescents. Adolescent participants also reported being less concerned with the possibility of relapse than their adult counterparts. In the current study, participants were not asked directly about the stages of change, but were asked to talk about their progress through questions that were grouped according to the stages of change. Findings in the current study seemed consistent with Hemphill and Howell's finding that participants did not seem to see much difference between the stages of pre-contemplation and contemplation, and placed a great deal of emphasis on action. This could be due to the fact that they did not begin the change process of their own volition; instead they were court-ordered to come to the program and in some ways were forced to begin changing or receive consequences if they chose not to. In the current study, also consistent with Hemphill and Howell's study, participants talked less about their thoughts leading up to change and more about the actions they took to achieve change, and feelings they had about their actions afterward.

Brown, Melchior, Panter, Slaughter, and Huba (2000) studied the steps of change and entry into treatment in women with substance abuse, domestic violence, mental health needs and high-risk sexual behavior. They discovered that women were more likely to want to change around issues that had immediate harm to themselves or their children. The highest change score was readiness to change a domestic violence situation, followed by readiness to change high-risk sex behaviors, drug treatment, and emotional problems. The majority of women saw domestic violence as the most immediate threat, therefore they were most likely to first take steps to change this aspect of their lives. This study indicated that women do not have a single factor that causes them to want change, and that they were most likely to first address the most immediate threat to themselves and their children. The current study found some similarities to this study, though they apply somewhat differently to the adolescent female than to the adult female. One similarity was that there did not seem to be one single factor that caused participants to change. Rather, each participant had a number of aspects of their lives they wanted to change for a variety of reasons. In terms of changing aspects that had the most immediate threats, this factor appeared in the current study in their work with their families. For an adolescent, not having a family would probably be the most immediate threat, even over other high risk behaviors; therefore they would want to improve their family relationships prior to trying to change other behaviors, such as drug use or truancy. Participants seemed to realize that they would need their families' support if they were to continue their positive behavior after treatment.

Therefore, it did seem like participants in the current study might have prioritized in a way that is similar to the adult women in the previous study. Both seemed to view their family relationships as the most immediate threat to their survival, and wanted to change this first. For many, improving their family relationships was the main aspect of their lives that they recognized as problematic prior to entering treatment.

Burns et al (1999) found that residential treatment is more effective when the resident's family is actively involved throughout their treatment. This seemed to be true in the current study as well. The program in the current study requires parents to be very involved, attending family sessions and a parent support group weekly. In addition, parents play a key role in participants' home visits each weekend. Participants reported that family counseling was very important to them in making changes in their own behavior. Participants also spoke about how important it was for them to hear positive feedback from their families, and know that their families were noticing the changes they were making.

A further finding is that the symptoms of the resident usually decrease while the resident is actually in treatment. Residential treatment has been associated with a reduction of psychopathology at discharge as well as decreased aggression, high-risk behaviors, depression and psychotic features (Connor, Miller, Cunningham & Melloni, 2002; Hussey & Guo, 2002). It appeared that this was true for the current study as well. Based on self-report, participants' symptoms decreased while they were in the program. Decreased aggression was also seen, particularly in Katrina and Trudy, who had reported significant

anger and aggression issues prior to coming to the program, and a dramatic decrease in their anger as a result of treatment. One high risk behavior that was common in the past for participants in the current study was running away, which none reported doing while in the program, and evidenced by the fact that they were still present to complete interviews. Participants in the current study were not asked specifically about other high risk behaviors, so it is unknown if these decreased, though this appears to be the case based on their answers to the other interview questions. Depression also seemed to decrease while in treatment based on participants' responses. Trudy described feeling "happier" and Penelope described her mind feeling less "cloudy" as a result of treatment. Both Katrina and Trudy reported similar feelings of being less stressed and also more hopeful about the future, which may be interpreted as less depressed. Participants in the current study did not report any psychotic episodes in the past, nor did they seem psychotic during interviews, so it appears the decrease in psychotic features does not apply to the current study.

Marholin, Pliwnis, Harris and Marholin (1975) implemented a behavioral approach at a residential program for adjudicated adolescent females. Their program was effective at improving grades in the majority of the girls in the program. In addition, tardiness, truancy, and absences decreased, and they noticed a difference in residents' attitudes toward school. While the current study did not directly address the academic performance of participants, they mentioned their school experiences in their interviews. Most notable was

Katrina, who spoke about her improved performance in school and her desire to finish high school after her recent positive experiences in school.

Munson and Revers (1986) examined the program effectiveness of a residential treatment center for emotionally disturbed adolescent females as measured by exit personality tests. They found that residents had developed more pro-social attitudes, increased trust, particularly with authority figures, and felt less threatened by negative or angry emotions. They also found that older adolescent females demonstrated greater internalization of the pro-social beliefs of the program. In the current study, there were similar findings in terms of participants reporting more positive attitudes, increased trust, and better anger management skills.

In her study of adolescent females' adjustment to group home care, Rafal (1991) found that girls who were placed in residential care due to the death of a parent, girls who were older at the time of their admission, or had histories of suicidal behavior, adjusted best to residential treatment. Conversely, girls with a history of runaway behavior, truancy, or academic problems were found to have the most trouble adjusting. In the current study, these findings did not seem to be replicated. The majority of the participants in the current study reported some sort of runaway behavior, truancy or academic problems prior to coming to the program. These girls reported doing well in the program and making positive changes. None of the girls in the current study reported being in residential treatment due to the death of a parent or any previous suicidal behavior, so it is difficult to make comparisons in those categories.

The Family Home Program (Larzelere, Daly, Davis, Chmelka & Handwerk, 2004) was an effective mode of treatment for both boys and girls. The majority of adolescents were discharged to a significantly less restrictive environment following treatment, with the majority of girls returning to the home or living independently. Both boys and girls had fewer DSM-IV diagnoses on the twelve-month follow up than at intake. In the current study only girls were studied. None of these girls had been discharged at the time of their interviews, so it is impossible to know if they returned to a less restrictive environment, however, their interviews seemed to indicate that this was what the majority planned upon discharge. Though the DSM-IV diagnoses were not known in the current study, participants' responses indicate that their functioning increased and symptoms decreased as a result of treatment.

### Study Limitations

There were several limitations to this study. The first was a small sample size of four participants. Though the program can hold twelve girls, it was not at capacity during this time. In addition, during the time this study was conducted several residents ran from the program, and several others were transferred either to a different facility or back to detention due to non-compliance.

A further limitation is that based on the inclusion criteria for the current study, all participants had to have been in the program for at least 4 months in order to be eligible. Therefore this study only included adolescent girls for whom the program seemed to work, judging by the fact that they had not run away or been terminated and were able to be interviewed. It would be interesting to

compare these participants to participants for whom the program did not seem to work, and who were no longer in the program by the four month mark.

The process of change developed in this study was based on four interviews, and could be more in depth and specific had there been more participants available. This limitation shows a major problem in working with this population, as treatment can often be interrupted for a variety of reasons. For adolescent girls in particular, the running away behavior makes it difficult to collect data, as it is common for this population and a very often is the cause of probation in the first place. This demonstrates both the importance and difficulty of establishing and maintaining connection with this population.

A further limitation is that based on the inclusion criteria for the current study, all participants had to have been in the program for at least 4 months in order to be eligible. Therefore this study only included adolescent girls for whom the program seemed to work, judging by the fact that they had not run away or been terminated and were able to be interviewed. It would be interesting to compare these participants to participants for whom the program did not seem to work, and who were no longer in the program by the four month mark.

One factor that could be seen as both a limitation and as an asset is my employment with this treatment program as a counselor. Though this was helpful in many ways, it could also greatly affect how participants experienced the interview and answered questions. It was made very clear to participants that the interview was different from their normal counseling sessions, would be kept confidential from other counselors, and in no way could affect their probation or



length of stay. Despite this, they still might have had reservations about being completely honest either because they felt pressure due to my position of counselor, or because they might have wanted to please me and “say the right thing” for the interview. On the other hand, the fact that I was a familiar figure to the participants may have made them feel more comfortable sharing than they would have if the interviewer were a complete stranger.

Another way that my employment may have impacted the study was prior knowledge of the participants and their histories. It was difficult for me to keep the information I knew about them previously from the information they gave me in their interviews. I tried my best to keep these separate and to focus on the interview data for this study by journaling about my feelings and reactions during the interview process. By journaling about my own reactions, I felt I was able to better separate my previous knowledge from the information I learned in interviews. I felt that this process helped me to view the data in a less biased way. Finally, my role as a counselor and relationship with participants could have led me to be biased in my coding of the data, perhaps attributing more or different meaning to their words based on my relationship and previous interactions with participants. To limit this possibility of a personal bias, my advisor also read and coded the data.

Another limitation to this study is the lack of diversity. Three out of the four participants in my study were Hispanic, and one was Caucasian. Therefore the majority of the interviews represent the experience of the Hispanic female in

residential treatment. Further research would need to be done to determine how the experience differs for other ethnicities.

A final limitation is the developmental level of the participants. Depending on their level of development, adolescents can lack the ability to think abstractly about themselves and others. Therefore, the results and discussion in this study are limited in that they are given meaning based on the researcher's interpretation of their words at times, rather than participants' own interpretations.

### Self of the Researcher

There is no doubt that my employment as a counselor at this treatment program shaped my lens of how I viewed the data. Though none of the participants in the study were specifically assigned to me as my individual cases, I had prior relationships with all of them that shaped the way I viewed their stories. My work with the girls in this program has been both very rewarding and difficult. While it can be extremely rewarding to see them make changes and gain self-confidence, it can also be heart breaking to hear about the circumstances they grew up in and see firsthand how these circumstances continue to affect them. Being a counselor to this population of adolescent girls can feel very overwhelming. On the one hand, they rely on you in order to get almost all of their needs met, both physical and emotional. It can be a very positive experience to be able to consistently meet their needs for possibly the first times in their lives. At the same time, it is always in the back of my mind that most of these girls will be returning home an environment that is less than perfect. It can be difficult to balance meeting their needs, while also helping

them learn how to meet these needs themselves eventually. Working with this population is both full of hope and sadness for me. As a researcher, I possessed these same feelings, which no doubt influenced how I chose to interpret the results of this study.

### Clinical Relevance

The findings of this study have important implications for clinicians working in residential treatment with this population. First of all, working in residential treatment with adolescents can be very challenging work, sometimes frustrating and slow. I believe that it could be extremely helpful for counselors to be able to identify approximately where these clients are in their process of change. This could help them with possible frustration in work with these clients, whose defiant or “laissez faire” attitudes are common in the beginning of treatment. Being familiar with the process of change could also help counselors to know what to expect of clients’ readiness for treatment, as well as allow counselors to tailor treatment to best meet their clients’ needs in each step of the change process. This knowledge could help prevent some of the burnout that is frequent for counselors in residential treatment.

It could also be helpful for counselors to know and be reminded of the importance of their role in the change process for their clients. Participants in the current study spoke at length about how helpful staff were to them during treatment. This could be helpful for counselors to think about with more challenging clients as well as during difficult times with any client. This theme of relationships with staff being instrumental to change seemed to fit with

Attachment Theory, which provided an additional lens through which to view the findings.

Attachment theory was first developed by John Bowlby in the 1940s. Bowlby used the term “attachment bond” to describe “a warm, intimate and continuous relationship with a mother or permanent mother substitute in which both find satisfaction and enjoyment” (Bowlby, 1953, p. 13). Bowlby described the attachment bond as the means through which an infant seeks comfort from their caregiver and develops a sense of security. Attachment theory suggests that a strong bond between mother and child in infancy will predict positive social and emotional outcomes for the child later in life. Having a caregiver who is consistent and reliable helps children to develop and regulate their own behaviors and emotions and develop a secure attachment. If a caregiver is ambivalent, rejecting or avoidant, a child learns that he or she cannot rely on the caregiver to meet attachment needs, suppresses their feelings and becomes anxiously, ambivalently, or avoidantly attached (Bowlby, 1953).

Attachment relationships, whether secure or insecure, form the basis for what Bowlby called the “internal working model” (Bowlby, 1953). The internal working model helps people to attach meaning to their experiences and relationships based on their attachment style and early childhood relationships; therefore an individual’s attachment style greatly affects how he or she views the world.

The majority of research on attachment figures has focused on the relationship between an infant and its mother, though alternative attachment

figures have been acknowledged since the beginning of attachment theory. One area of research addresses the attachment between child care workers and the children in their care. Research has suggested that infants do form attachment relationships with non-parental caregivers that care for them consistently for a period of time (Sagi, van IJzendoorn, Aviezer, Donnell, Koren-Karie, Joels & Harvel, 1995). Further research has suggested that mental health care institutions could possibly serve as a positive attachment figure for patients, particularly patients that did not have the experience of a secure attachment in childhood (Adshead, 1998.) As the role of the caregiver to an infant is to develop a capacity to think and tolerate anxiety (Bowlby, 1953), mental health workers may be able to encourage these same skills in their patients long after infancy.

It has been suggested that mental health workers might further help to create a secure base by being available in times of distress and through consistent and reliable interaction with the patient. The consistency of their interactions and responses might help the patients begin to trust the mental health worker and possibly change their internal working model (Adshead, 1998). In one study on children with intellectual disabilities, data suggested that professional caretakers have potential to be attachment figures for this population (De Schipper, J., Stolk, J., Schuengel, C., 2006). The idea that an individual might be able to develop an alternative attachment figure is of interest to the current study. Through the lens of attachment theory, it is hypothesized that participants' relationships with staff were instrumental in helping them to make changes, as these relationships offered a secure base from which to

explore themselves. In the context of an alternative attachment, the current study could be beneficial in helping counselors view themselves as alternative attachment figures, and help them to be more intentional about how they use this in treatment.

Furthermore, participants reported feedback from staff was very meaningful to them. It could be helpful for counselors to know more about the importance for their clients to hear feedback from them, even for small accomplishments, and to make an effort to give clients feedback whenever they can.

Finally, it could be beneficial for clients and their families to have knowledge of the change process for this population. Many parents come into family sessions feeling just as hopeless about change as do their daughters. It could be helpful for them to learn about the change process for other girls in the program and normalize some of what they may view as indifference or reluctance to change. Further knowledge of the change process might also help parents to recognize and verbalize changes they notice in their daughters, as many participants reported feeling frustrated when their families were not noticing or commenting on their positive changes.

#### Suggested Future Research

There are still many missing pieces in terms of knowledge about residential treatment for adolescent females. One aspect that would be helpful would be additional follow- up data on how well changes are maintained months and years after treatment is over. It would be interesting to see this in the form of

qualitative data, as quantitative data does not always capture the full picture of the experience of the participants. It would be beneficial to see participants' views on their success in maintaining changes, in addition to data on recidivism in the years following their treatment. For some of these girls, less contact with the legal system may be a more realistic expectation rather than no contact at all.

Another area that needs further research is substance abuse, and how this is treated in residential facilities that do not specifically target substance abuse. This was not widely explored in the current study, and it would be interesting to hear residents' perspectives on how well this is addressed and what aspects of this treatment they find helpful.

Other topics that would be interesting to explore would be the experiences of parents and counselors in residential treatment. By exploring the parents' experiences of program participation, changes could be made to help them feel more included in their daughter's treatment, as well as facilitate a smoother transition home. By exploring the counselor's experience working in residential treatment, program directors could better address the challenges they face and provide training around these issues. This might be helpful in preventing staff burnout and preventing high staff turnover that residential treatment centers are known for.

Residential treatment is a treatment modality that still has yet to be fully understood. The current study attempted to explore the change process as one aspect of residential treatment, with the hopes that this will contribute to the greater understanding, utilization, and efficacy of residential treatment.

## References

- Adshead, G. (1998). Psychiatric staff as attachment figures: understanding management problems in psychiatric services in the light of attachment theory.. *British Journal of Psychiatry*, 172, 64-69.
- Bates, B., English, D., & Kouidou-Giles, S. (1997). Residential treatment and its alternatives: A review of the literature. *Child & Youth Care Forum*, 26(1), 7-51.
- Bergsmann, I.R. (1989). The forgotten few: Juvenile female offenders. *Federal Probation*, 53, 73-78.
- Binder, A. (1988) Juvenile delinquency. *Annual Review of Psychology*, 39, 253-282.
- Bowlby, J. (1953). *Child care and the growth of love*. Melbourne, Australia: Penguin
- Books.
- Brown, V.B., Melchior, L.A., Panter, A.T., Slaughter, R., & Huba, G.J. (2000) Women's steps of change and entry into drug abuse treatment: A multidimensional stages of change model. *Journal of Substance Abuse Treatment*, 18, 231-240.
- Burns, B., Hoagwood, K., & Mrazek, P. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Child and Family Psychology Review*, 2(4),



199-254.

Cardoso, E.D., Fong, C., Berven, N.L., & Thomas, K.R. (2003). Measuring readiness to change among individuals in residential therapeutic community programs for treatment of substance abuse. *Rehabilitation Counseling Bulletin, 47, 34-45.*

Cohen, M.A. (1998). Monetary value of saving a high-risk youth. *Journal of Quantitative Criminology, 14, 5-33.*

Connor, D.F., Doerfler, L.A., Toscano, P.F., Volungis, A.M., & Steingard, R.J. (2004). Characteristics of children and adolescents admitted to a residential treatment center. *Journal of Child and Family Studies, 13, 497-510.*

Connor, D.F., Miller, K.P., Cunningham, J.A., & Melloni, R.H. (2002) What does getting better mean? Child improvement and measure outcome in residential treatment. *Journal of Orthopsychiatry, 72, 110-117.*

Cuellar, A.E., McReynolds, L.S., & Wasserman, G.A. (2006). A cure for crime: Can mental health treatment diversion reduce crime among youth? *Journal of Policy Analysis and Management, 25, 197-214.*

Curry, J.F. (1991). Outcome research on residential treatment: Implications and suggested directions. *Journal of Orthopsychiatry, 61, 348-357.*

Da Silva Cardoso, E., Chan, F., Berven, N., & Thomas, K. (2003). Measuring Readiness to Change Among Individuals in Residential Therapeutic Community Programs for Treatment of Substance Abuse. *Rehabilitation Counseling Bulletin, 47(1), 34-*

45.

Dembo, R., Wareham, J., Chirkos, T.N., & Schemeilder, J. (2005). Economic impact on the justice system from reductions in diversion program funding. *Journal of Offender Rehabilitation, 41, 63-91.*

Department of Juvenile Justice, Richmond VA, Report on Audit for 2002.

De Schipper, J., Stolk, J., Schuengel, C. (2006). Professional caretakers as attachment figures in day care center for children with intellectual disability and behavior problems. *Research in Developmental Disabilities, 27, 203-216.*

Dowd, T., Herron, R., Hyland, T., & Sterba, M. (1998). *Issues in Quality Child Care: A Boys Town Perspective.* Nebraska, Boys Town Press.

Foa, E.B. & Riggs, D.S. (1995) Posttraumatic stress disorder following assault: Theoretical consideration and empirical findings. *Current Directions in Psychological Science, 4, 61-65.*

Gossett, J., Lewis, J., & Barnhart, F. (1983). *To find a way: The outcome of hospital treatment of disabled adolescents.* New York, Brunner / Mazel.

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

Hawkins, R.P., Almeida, M.C., Fabry, B., & Reitz, A.L. (1992). A scale to measure restrictiveness of living environments for troubled children and youths. *Hospital & Community Psychiatry, 43, 54-58.*

- Hemphill, J.F., & Howell, A.J. (2000). Adolescent offenders and stages of change. *Psychological Assessment, 12*, 371-381.
- Hoge, R.D., Andrews, D.A., & Leschied, A.W. (1995). Investigation of variable associated with probation and custody dispositions in a sample of juveniles. *Journal of Clinical Child Psychology, 24*, 279-286.
- Hooper, S.R., Murphy, J., Devaney, A., & Hultman, T. (2000). Ecological outcomes of adolescents in a psycho-educational residential treatment facility. *American Journal of Orthopsychiatry, 70*, 491-500.
- Howes, C. (1999). Attachment relationships in the context of multiple caregivers. *Handbook of attachment: Theory, research, and clinical applications* (pp. 671-687). New York, NY US: Guilford Press.
- Hussey, D.L. & Guo, S. (2002). Forecasting length of stay in child residential treatment. *Child Psychiatry and Child Development, 36*, 95-111.
- Jenson, J., & Whittaker, J. (1989). Partners in care: Involving parents in children's residential treatment. *Residential and inpatient treatment of children and adolescents* (pp. 207-227). New York, NY US: Plenum Press.
- LaRossa, R. (2005). Grounded theory methods and qualitative family research. *Journal of Marriage and Family, 67*(4), 837-857.
- Larzelere, R.E., Daly, D.L, Davis, J.L., Chmelka, M.B. & Handwerk, M.L. (2004). Outcome Evaluation of Girls and Boys Town Family Home Program. *Education and Treatment of Children, 27*, 130-149.

- Marholin, D., Plienis, A.J., Harris, S.D., & Marholin, B.L. (1975). Mobilization of the community through a behavioral approach: A school program for adjudicated females. *Criminal Justice and Behavior*, 2, 130-145.
- McConaughy, E.A., Prochaska, J.O., & Velicer, W.F. (1983) Stages of change in psychotherapy: Measurement and sample profiles. *Psychotherapy: Theory, Research, and Practice*, 20, 368-375.
- Menses, G., & Durrant, M. (1990). Contextual residential care: The application of the principles of cybernetic therapy to the residential treatment of irresponsible adolescents and their families. *Residential Treatment for Children & Youth*, 7(3), 11-32.
- Munson, R., Klein, R., & Delafield, D. (1989). Treatment of adolescents in a residential facility: A study of three approaches. *Adolescence*, 24(96), 817-820.
- Munson, R., & Revers, M. (1986). Program effectiveness of a residential treatment center for emotionally disturbed adolescent females as measured by exit personality tests. *Adolescence*, 21, 305-310.
- Oles, T. (1991). Resident's perceptions of change: A basis for after care. *Residential Treatment for Children & Youth*, 9(1), 29-37.
- Owen, I. (1994). Introducing an existential-phenomenological approach: Basic phenomenological theory and research: I. *Counseling Psychology Quarterly*,

7(3), 261-273.

Pillari, V. (1992). Family myths among female adolescents in a residential setting. *Child*

*& Adolescent Social Work Journal*, 9(1), 77-88.

Plapp, J. (1983). Some characteristics of adolescents who present significant management

problems in residential psychiatric treatment. *Australian Psychologist*, 18(1), 107-

115.

Prochaska, J.O., & DiClemente, C.C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice*, 19, 276-288.

Prochaska, J.O., DiClemente, C.C. & Norcross, J.C. (1992) In search of how people change: Applications to addictive behaviors. *American Psychologist*, 47, 1102-1114.

Rafal, A.S. (1991). The adolescent girl's adjustment to group home care: A pilot study. *Residential Treatment for Children and Youth*, 9, 5-15.

Sagi, A., Van IJzendoorn, M., Aviezer, O., Donnell, F., Koren-Karie, N., Joels, T., &

Harel, Y. (1995). Attachments in a multiple-caregiver and multiple-infant environment: the case of the Israeli kibbutzim. *Monographs of the Society for Research in Child Development*, 60, 71-91.

Shaffer, D., Fisher, P., Dulcan, M.K., Davies, M., Piacentini, J., & Schwab-Stone, M.E., et al. (1996). The NIMH diagnostic interview schedule for children version 2.3 (DISC-2.3): Description, acceptability, prevalence rates, and

- performance in the MECA study. *Methods for the epidemiology of child and adolescent mental disorders study. Journal of the American Academy of Child and Adolescent Psychiatry, 35, 865-877.*
- Shapiro, J.P., Welker, C.J., & Pierce, J.L. (1999). An evaluation of residential treatment for youth with mental health and delinquency-related problems. *Residential Treatment for Children and Youth, 17, 33-48.*
- Stage, S. (1999). Predicting adolescents' discharge status following residential treatment. *Residential Treatment for Children & Youth, 16(3), 37-56.*
- Sunseri, P.A. (2001). The prediction of unplanned discharge from residential treatment. *Child & Youth Care Forum, 30, 283-303.*
- Synder, H. & Sickmund, M. (2006). *Juvenile Offender and Victims: 2006 National Report.* Pittsburg, PA: National Center for Juvenile Justice.
- Townsend, M., & Hansen, J. (1986). The nature of friendship, leadership, and social support among adolescent girls in a social welfare home. *New Zealand Journal of Educational Studies, 21(2), 158-167.*
- Trupin, E.W., Stewart, D.G., Beach, B., & Boesky, L. (2002). Effectiveness of a dialectical behavior therapy program for incarcerated female juvenile offenders. *Child and adolescent mental health, 7, 121-127.*
- Wells, K. (1991). Long term residential treatment for children: Introduction. *American Journal of Orthopsychiatry, 61, 324-326.*

Winters, K.C., Stinchfield, R.D., Opland, E., Weller, C., & Latimer, W.W. (2000).

Effectiveness of Minnesota Model approach in treatment of adolescent drug abusers. *Addiction*, 95, 601-612.