Therapists' and Families' Views on Family Involvement in Adolescent Residential Treatment

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THERAPISTS’ AND FAMILIES’ VIEWS ON FAMILY INVOLVEMENT IN ADOLESCENT RESIDENTIAL TREATMENT

by

Jonathan D. Zabriskie

A thesis submitted in partial fulfillment of the requirements for the degree of MASTER OF SCIENCE in Family, Consumer, and Human Development (Marriage and Family Therapy)

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Therapists’ and Families’ Views on Family Involvement in Adolescent Residential Treatment

by

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Utah State University, 2011

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This study of 24 therapists and 64 family members representing 109 adolescent residents of six residential treatment centers aimed to better understand therapists’ and family members’ points of view about family involvement in residential treatment for troubled adolescents. The study also provided the therapists’ and family members’ recommendations for family involvement in residential treatment.

Findings from this mixed-methods study suggest that (a) the families from this study were involved in many different ways in their adolescents’ treatment, including phone calls, visits to the treatment center, participation in therapy, and so forth; (b) there were areas in which therapists and family members agreed (e.g., whether families used phone calls as a form of contact) and areas in which they disagreed about how involved the families were in treatment and therapy (e.g., how often any family member was involved in therapy with the adolescent); and (c) the therapists and family members
recommended that families should be involved in therapy but recommend some forms of involvement over others.
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A project of this magnitude would not have been possible without the help of many important people who have inspired, supported, and encouraged me. It is not possible to list here all of those whom I should thank for helping me to accomplish what I have. However, I would like to thank several people who have simply been the difference between completing this project and not completing this project.

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A significant percentage of adolescents in the United States experience difficulties that affect their everyday lives. Some adolescents have behavioral problems such as aggression or delinquency (Bloomquist & Schnell, 2002). Other adolescents experience problems related to the use and abuse of mind-altering substances (Burrow-Sanchez, 2006). Still others experience problems tied to physical, sexual, or emotional abuse (Cruise, Jacobs, & Lyons, 1994; Tromovitch & Rind, 2007) or mental health issues (American Psychiatric Association [APA], 2000). Resolution of these problems is usually sought through outpatient (psychotherapy or family therapy) or inpatient treatment (e.g., psychiatric hospitalization). One common form of inpatient treatment for adolescents is residential treatment.

Residential treatment centers (RTCs) are spread throughout the United States. Treatment centers are often home-like and house adolescents under the constant care of trained staff. Some involve schooling on site; adolescents in others are mainstreamed into public schools. Some are privately funded through client fees; others are primarily state funded for adolescents in the care of their respective states.

These centers house adolescents on a 24/7 basis where their presenting problems are diagnosed and treated. Approaches to treatment vary based on the presenting problems of the adolescents in treatment and on the administration and staff of the RTC. One aspect of treatment that differs between RTCs is the presence and extent of family involvement both in the adolescent’s treatment in general (e.g., phone calls from family members) and in therapy specifically (RTC therapy sessions that include family
members). Social policy is stressing the importance of families’ continued involvement with adolescents in residential treatment (Baker, Blacher, & Pfeiffer, 1996). This involvement can come in the form of the family’s simply having contact with the adolescent in treatment through phone calls, physically visiting the treatment center, or being involved through participating in therapy sessions with the adolescent in residential treatment (Nickerson, Brooks, Colby, Rickert, & Salamone, 2006).

Although many studies have looked at families’ contact with their adolescents in treatment, few studies have discussed family involvement in RTC therapy. One study (Nickerson et al., 2006) compared therapists’ and families’ experiences in RTC treatments that involved families. However, no other studies in the literature have taken such an approach. The purpose of this study is to examine the differences between therapists’ and families’ opinions about family involvement in both treatment in general and RTC therapy.

This study followed a descriptive design. Therapists and families of adolescents in Utah residential treatment centers were surveyed regarding their opinions about the level to which the families were involved in the residential treatment process. These participants were asked to answer multiple-option and open-ended questions in an effort to determine trends among participants’ answers and differences in perspectives between therapists and families. Participants were also asked their opinions about optimal family involvement in residential treatment and therapy.
CHAPTER II
LITERATURE REVIEW

The Need for Adolescent Intervention

Adolescents—individuals between the ages of 11 and 18 old—are faced with many issues, some of which require intervention. Although some adolescents may have only one presenting issue, others suffer from comorbid disorders (Baker, Blacher, & Pfeiffer, 1993; Couwenbergh et al., 2006; Youngstrom, Findling, & Calabrese, 2003). Some of these issues may include maltreatment, a history of behavioral problems, substance use and abuse, physical and/or sexual abuse, or mental health concerns (Baker, Archer, & Curtis, 2007; Baker, Fulmore, & Collins, 2008; Crenshaw & Foreacre, 2001).

Statistically, male and female adolescents differ in the kinds of problems they experience that require treatment (Baker et al., 2007; Harper, Russell, Cooley, & Cupples, 2007). Baker and colleagues (2007) claimed that male adolescents compared to females were significantly more likely to have histories of criminality, but significantly less likely to have legal statuses of abuse or neglect, histories of sexual abuse, or histories of suicidal ideation than their female counterparts. Furthermore, Harper and colleagues (2007) found that females enter treatment primarily for mental health problems although males do so for problems with both drug and alcohol use and school performance.

There are also differences in interventions based on ethnicity. Ringel and Sturm (2001) argued that black and Hispanic adolescents and children have a greater need for mental health services than white and other minority children. They also reported that
Hispanic and other minority adolescents and children have a greater unmet need for mental health services than black and white children (Ringel & Sturm, 2001).

Adolescent Problems That Necessitate Intervention

Behavioral Problems

Bloomquist and Schnell (2002) discussed several common behavioral problems exhibited by adolescents including overt aggression, reactive aggression, relational aggression, bullying, violence, covert aggression, and child delinquency. Specifically, overt aggression, covert aggression, and juvenile delinquency are discussed here. Connor, Melloni, and Harrison (1998) defined overt aggression as “openly confrontational hostile behavior (threats, physical fighting)” (p. 67). They further categorized overt aggression into four different areas: physical assault, verbal threats of violence, property destruction, and self injury. Loeber and Stouthamer-Loeber (1998) stated that overtly aggressive acts include fighting and delinquent crimes with direct confrontation, such as rape, assault, and robbery.

Another common behavioral problem among adolescents is covert aggression (Bloomquist & Schnell, 2002). Examples of such behaviors include lying, cheating, smoking, drinking, disobeying, and truancy (Bloomquist & Schnell, 2002; Connor et al., 1998). Although such behaviors are less serious than most overt problem behaviors (e.g., rape), the consistent appearance of such behaviors in adolescents deserves attention from parents, legal guardians, and/or other loved ones who care for those adolescents.
Yet another common behavioral problem that has some overlap with both overt
and covert aggression is juvenile delinquency (Bloomquist & Schnell, 2002).
Delinquency is a legal term and is used when a child or adolescent’s behavior is serious
enough that courts are involved (Kazdin, 1987). Flannery, Hussey, and Jefferis (2005)
reported that juveniles who are delinquent are more likely to become adult offenders than
those who are not. Thus, federal, state, and local governments in the United States are
debating over the proper way to intervene for juvenile delinquents (Mincey, Maldonado,
Lacey, & Thompson, 2008). The fact that government entities are seeking a sensible
approach to such an issue underscores the importance placed upon intervention for
adolescents with behavioral problems.

**Substance Use and Abuse**

Although many adolescents experiment with some form of chemical substance,
only a small portion develop problems that affect their development and adult lives
(Burrow-Sanchez, 2006). Nevertheless, those who do develop disorders related to
substance abuse usually experience poor academic performance, job instability, teen
pregnancy, and transmission of sexually transmitted diseases (Sussman, Skara, & Ames,
2008). Hawkins (2009) explained that the term *substance abuse disorder* “encompasses
both abuse and dependence” and “is characterized by a maladaptive pattern of use that
results in significant and recurrent negative consequences, such as failure to fulfill major
role obligations, use in situations that are physically dangerous, legal problems, and
social or interpersonal difficulties” (p. 199).
The overall rates of alcohol and drug misuse and abuse change over time, and actually have decreased from their highest levels in the 1970s (Leukefeld, McDonald, Stoops, Reed, & Martin, 2005). Burrow-Sanchez (2006) reported findings based on a U.S. nationally representative sample from 2002 of adolescents in 8th, 10th, and 12th grades that the most common substances used in all three grades were alcohol, cigarettes, and marijuana. One possible explanation for such a finding is the increased access, availability, and affordability of alcohol and cigarettes to adolescents.

**Physical and Sexual Abuse**

The meanings of terms such as physical abuse or child abuse vary in the literature simply because historically, there has not been agreement on the definitions of the terms (Cruise et al., 1994; Starr, 1979). It is common to see the terms sexual abuse and child sexual abuse used as distinct and separate. However, definitions of the latter vary because of ambiguity regarding what constitutes sexual abuse and who is considered a child. For example, Tromovitch and Rind (2007) argued that it is inappropriate to casually lump adolescents into definitions of child sexual abuse. Nevertheless, any abuse that an adolescent experienced as a child or in his or her adolescent years is important to consider when deciding whether treatment is appropriate and which treatment would be most helpful for the individual.

Efforts to determine the prevalence of physical and sexual abuse among adolescents are greatly affected by the fact that adolescents are generally reluctant to report abuse that goes on in their homes (Hawke, Jainchill, & De Leon, 2000). Nevertheless, there are some important patterns that have come to light through the
literature. For example, Grych and his colleagues (Grych, Jouriles, Swank, McDonald, & Norwood, 2000) claimed that children who feel that they have contributed to or have not prevented violent behavior in the family are likely to experience “feelings of anxiety, depression, helplessness, and low self-worth” (p. 92). Although studies such as this one suggest that there are adverse effects for children who witness domestic violence, higher levels of depression and trauma symptoms have been tied to adolescents’ personal experience of child abuse (Levendosky, Huth-Bocks, & Semel, 2002).

Empirical data have shown that child sexual abuse is one of three important contributory factors to abusive sexual behaviors in adolescents (Barbaree & Langton, 2006). It is disconcerting to read research regarding the percentage of sexual abuse perpetrators who are under the age of 18. Pithers and Gray (1998) conducted a study that included 127 children with sexual behavior problems, 84% of whom had been sexually abused themselves. Forty percent of the participants had been abused by other children who were 18 years old or younger. Furthermore, 96% of the participants fit the criteria for at least one disorder from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; APA, 2000), the most common of which were conduct disorder, attention deficit/hyperactivity disorder, and oppositional defiant disorder. These findings suggest that a large percentage of children who are sexually abused both suffer from mental disorders and sexually abuse other children.

**Mental Health Concerns**

There are many mental health problems with onset ages in the teenage years (APA, 2000). The common problems that are discussed here are depression (major and
minor), anxiety, bipolar disorder, and eating disorders. Major and minor depression are defined differently in the literature (Rohde, Beevers, Stice, & O’Neil, 2009), but minor depression simply involves fewer symptoms (two to four symptoms reaching the threshold) than major depression (five symptoms or more; APA, 2000).

Rohde and colleagues (2009) suggested that adolescence is a time in which females in particular are at high risk for the onset of depressive disorders. Among the participants of their study, one in six females experienced at least one episode of major depressive disorder between the ages of 12 and 20. Tanielian and colleagues (2009) reported similar trends in higher prevalence of depression among female teenagers compared to male teenagers.

Another common mental health problem among adolescents is anxiety (Connolly & Bernstein, 2007; Merikangas, Avenevoli, Dierker, & Grillon, 1999). Anxiety is difficult to define, simply because there are many different categories of anxiety, including generalized anxiety disorder, panic disorder, specific phobias (e.g., arachnophobia), and so forth (APA, 2000). There are likely many ways to account for anxiety disorders in adolescents. For instance, Merikangas and colleagues (1999) found that parental anxiety disorders are associated with anxiety disorders in their children.

Bipolar disorder—a combination of depressive and manic symptoms (APA, 2000)—appears to have an early onset for most individuals. Perlis and colleagues (2004) studied 983 participants who had been diagnosed with bipolar disorder I, II, or not otherwise specified (NOS). Study participants were selected based on their participation in the Systematic Treatment Enhancement Program for Bipolar Disorder (Sachs et al.,
2003). Of those participants, 272 (28%) reported that the onset of their symptoms occurred before the age of 13, while 370 (38%) more reported that their onset occurred before the age of 18, meaning a total of 65% of the participants experienced onset of symptoms in their teenage years or earlier (Perlis et al., 2004).

Finally, eating disorders involve one of three different diagnoses: (a) anorexia nervosa is diagnosed based on dietary restriction and low weight; (b) bulimia nervosa is characterized by binge eating and other compensatory behaviors (e.g., purging) but not being underweight; and (c) eating disorder NOS involves similar conditions that are related to eating disorders but are not better accounted for by some other mental health diagnosis (e.g., binge eating without purging; APA, 2000). Due to the behavioral components of eating disorders, these could be categorized as behavioral problems. However, they are categorized here as a mental health issue because of the pathological obsession with personal weight and shape that those who suffer from these disorders usually experience (Herpertz-Dahlmann, 2009).

**Effects of Problems on Adolescents and Their Families**

The issues listed above can have severe effects on adolescents and their families. For example, some adolescents who suffer from depression also experience and act on suicidal ideation (Stanard, 2000). Connolly and Bernstein (2007) argued that anxiety disorders interfere with the normal psychosocial development of adolescents. The illegal use and/or abuse of chemical substances increases the risk of an individual’s getting into legal trouble, particularly for young people (Burrow-Sanchez, 2006). de Boer, Cameron,
and Frensch (2007) found that families of troubled adolescents reported living with increased stress, fear of the potential for serious violence, and constant fatigue.

**Treatment of Adolescent Problems**

**Rationale for Treatment**

Finding effective treatment and intervention for the problems listed above is an important issue because of the negative effects of those problems. The majority of adolescents who struggle with these problems do not get the type of help or intervention they need. For example, Tanielian and her colleagues (2009) reported that among 184 participants of the Teen Depression Awareness Project, only 25% were receiving any type of treatment for their depression. Stanard (2000) argued that one important reason that children and adolescents should be treated for depression is the increased risk of completed suicide by those children and adolescents who suffer from depression compared to those who are not treated.

Interventions need to be more accessible to adolescents who use and abuse alcohol, cigarettes, and marijuana. Alcohol has a greater impact on an adolescent brain than on an adult brain because the adolescent brain is oversensitive to damage that results from the use of such substances as well as undersensitive to the warning signs of danger (Carbonell, Ballard, & Ponton, 2008). Chun, Guydish, and Chan (2007) reported that among over 900 adolescents in residential treatment and continuing care programs for substance abuse, 66% reported smoking sometime in the previous month. The mean age of those participants was 16 years (Chun et al., 2007). Regarding marijuana use,
Johnston, O’Malley, and Bachman (2003) reported on national findings of drug use among high school adolescents from 1975 to 2002 that at least 83% of every senior class had reported that they could access marijuana fairly easily.

**Costs Associated With Treating Adolescent Problems**

As noted by Ringel and Sturm (2001), there are few data in the literature regarding the cost of treating adolescents for the problems listed above. These same authors reported that the estimated overall cost of mental health services for children in 1998 alone was $11,680,000,000; 60% of this figure was attributed to services for adolescents (12 to 17 years old), 34% for children between the ages of 6 and 11, and 6% for children between the ages of 1 and 5 (Ringel & Sturm, 2001). Regarding costs associated with mental health services used to treat children in that year, 57% were related to outpatient care and 33% were related to inpatient care (Ringel & Sturm, 2001). However, of the three age groups in the study (ages 1 to 5, 6 to 11, and 12 to 17), the adolescent group had the lowest outpatient cost of care (Ringel & Sturm, 2001). It should be noted that Ringel and Sturm acknowledged the limitations of their efforts to estimate total expenditures because they were based on multiple data sources that were not necessarily comparable.

**Treatment Options for Troubled Adolescents**

Parents of troubled adolescents seek intervention in many different places (de Boer et al., 2007). Parents often begin their search for competent help in outpatient settings, such as mental health facilities. Others feel desperate enough to admit their
adolescents into inpatient settings due to the dangerous and unpredictable nature of their adolescents’ problems. Still others are ordered into treatment by schools or juvenile justice systems (T. Nelson, personal communication, February 28, 2011). In correctional and inpatient settings, adolescents can be watched and attended to on a much more consistent basis than in outpatient settings. Inpatient options for troubled adolescents include psychiatric hospitalization (Balkin, 2006), therapeutic foster care (Hahn et al., 2005), wilderness therapy (Becker, 2010; Hill, 2007), and residential treatment.

Treatment options are not available for all parents and families of troubled adolescents. For example, some authors have suggested that ethnic minorities have not been represented in mental health services as strongly as ethnic majorities (Balkin, 2006; Ringel & Sturm, 2001).

Psychiatric hospitalization is a short-term treatment option for troubled adolescents. Balkin (2006) considered length of stay and treatment utilization for adolescents of various ethnicities in acute-care psychiatric hospitalization programs. These programs involve crisis intervention that usually last no longer than 15 days (Balkin, 2006). Balkin found that minority clients stayed significantly longer than Caucasian clients and that clients paying for services with Medicaid stayed significantly longer than those who paid with private insurance.

Therapeutic foster care is a much more long-term option for troubled adolescents and their families than psychiatric hospitalization. It is also occasionally considered to be a form of residential treatment (Butler & McPherson, 2007), but is discussed here as a separate form of intervention. Adolescents who are part of therapeutic foster care
generally stay for at least six months (Hahn et al., 2005). Foster care involves placing the adolescent in a home where he or she is cared for by foster parents—individuals who are “trained to provide a structured environment for learning interpersonal skills and participating in positive social activities” (Hahn et al., 2005, p. 73). Therapeutic foster care may also include family therapy for the adolescents’ families in an effort to improve family functioning before the adolescent returns to his or her home (Hahn et al., 2005).

Wilderness therapy is also a longer-term treatment option. Wilderness therapy is primarily geared toward adolescents (Becker, 2010), unlike psychiatric hospitalization, that sometimes includes children and adults. Davis-Berman and Berman (as cited in Hill, 2007) defined wilderness therapy as traditional counseling in outdoor settings with the use of adventure-based activities. According to Becker (2010), other terms are used for wilderness therapy, such as adventure therapy, wilderness adventure therapy, and outdoor behavioral healthcare, all of which are used interchangeably.

Some treatment for adolescents is mandated by school or juvenile justice because these adolescents are breaking the law or are consistently interrupting the structure of a school environment. Detention centers and correctional facilities often are mandated in cases where adolescents have been arrested (Anderson, Nyamathi, McAvoy, Conde, & Casey, 2001). Thus, these forms of treatment are not sought out by the families of these adolescents, but rather are mandated by schools or states.
Adolescent Residential Treatment

Due to the diversity of services that are categorized under “residential treatment” such as group homes, therapeutic foster homes, treatment foster care, campus-based homes, and locked facilities, it is very difficult to clearly define the term (Butler & McPherson, 2007). However, a common element among many definitions of residential treatment is that the adolescents reside away from home in a non-family setting (Frensch & Cameron, 2002). Butler and McPherson (2007) explained that there are some who believe that residential treatment is an “antiquated provision of care that does little more than warehouse children” (p. 465) and argued that a more specific and uniform definition of residential treatment would provide both a basis for systematic research and an increase in viability and effectiveness.

Butler and McPherson (2007) indicated that a good definition of residential treatment requires the following components: “a therapeutic milieu, a multidisciplinary care team, deliberate client supervision, intense staff supervision and training, and consistent clinical/administrative oversight” (p. 469). Residential treatment traditionally has been a long-term treatment option that can last up to a year or more, but more recently, with the increased use of brief therapy at the insistence of insurance managed care, residential treatment may last only three months (Leichtman, Leichtman, Barber, & Neese, 2001).

Many experts argue that there are a significant number of adolescents in need of long-term, intensive residential treatment (Butler & McPherson, 2007; Jones, 1985; Nickerson, Colby, Brooks, Rickert, & Salamone, 2007). As has been demonstrated,
residential treatment is one of many options available to parents who feel that they are unable to control their adolescent’s behavior at home (Landsman, Groza, Tyler, & Malone, 2001). For many parents, however, it is a last-option approach (Blacher, 1994; de Boer et al., 2007) to helping their children when multiple outpatient attempts and/or psychiatric hospitalization have proven to be insufficient or ineffective (Connor, Doerfler, Toscano, Volungis, & Steingard, 2004; Leichtman et al., 2001; Mikkelsen, Bereika, & McKenzie, 1993; Nickerson et al., 2007). The challenge then becomes an issue of ensuring that adolescents in residential treatment get the help they need for their presenting problems, while simultaneously avoiding the tendency to treat them in isolation from their families. In almost all cases, isolated treatment is not effective (Goyette, Marr, & Lewicki, 1994).

Justifying the use of residential treatment is an issue of whether doing so is an effective approach for troubled youth. Although some parents may resort to residential treatment because nothing else works (Leichtman et al., 2001), other parents want to know whether research supports this type of intervention. Some (e.g., Butler & McPherson, 2007; Landsman et al., 2001; Pumariega, 2007) argue that the outcome literature available has not been successful in supporting the contention that residential or inpatient treatments produce positive outcomes. Others (Harper et al., 2007) claim that even if adolescents improve in treatment, the outcome may not translate to sustained improvement in family functioning that could help the adolescent maintain changes. Still others (Mikkelsen et al., 1993) believe that residential treatment is a desirable alternative
to psychiatric hospitalization, for example, and therefore do not consider treatment outcomes before admitting adolescents to residential treatment.

Pumariega (2007) summarized some of the negative effects of residential treatment based on reviewed research studies, including potential abuse of the adolescents by staff members and the feeling by some adolescents that their roles and positions in their families are displaced or eliminated due to their extended absences from home. It is commonly reported in the literature that successes achieved by adolescents in residential treatment are difficult to maintain, particularly when the adolescent returns home, and often dissipate over time (Frensch & Cameron, 2002). Such failures can be demoralizing both for adolescents and their families and may require further treatment.

There also are many positive reasons why residential treatment can be and is an effective source of treatment for troubled adolescents. Residential treatment programs have been shown to improve functioning of some adolescents (Frensch & Cameron, 2002). Hair (2005) reported that adolescents who are involved in residential treatment are able to live in a less intrusive setting, maintain gains as best as they can, stay out of trouble, and achieve important life markers such as completing school.

The benefits of residential treatment are not limited to the adolescents who are admitted into residential treatment. The parents and siblings of these adolescents also benefit from residential treatment services. de Boer and colleagues (2007) conducted a study aimed at finding whether the families of adolescents in residential treatment benefited from the services as well as the adolescents. The majority of the 29 parents who participated in this study of two treatment centers reported that they were able to
find more stability and thus make positive changes of their own once their children were admitted into residential treatment. This study was limited, however, due to a small and self-selected sample.

**Family Involvement in Residential Treatment**

As they are used in this paper, the terms *family* and *family involvement* are similar to those used by Kalke, Glanton, and Cristalli (2007): *Family* is any combination of the adolescent in residential treatment, a parent or primary caregiver, a guardian of the child, and/or any other individuals living in the same household of the adolescent at the time he or she entered residential treatment; *Family involvement* is “any role or activity that enables families to have direct and meaningful input into and influence on” their adolescent’s residential treatment (Kalke et al., 2007, p. 165).

Reunification with a family is not always the best indication that residential treatment was successful for an adolescent (Butler & McPherson, 2007; Nickerson et al., 2007). Other factors, such as the extent of the involvement of adolescents’ families in treatment and changes in the adolescents’ environments, including positive changes in family functioning, are important in the consideration of treatment success. Nickerson and colleagues (Nickerson, Salamone, Brooks, & Colby, 2004) suggested that family involvement is needed and that families should be involved and included as early as the initial assessment.

Residential treatment programs that utilize family involvement have been shown to be more successful at achieving stable outcomes over time than programs that do not include families (Lakin, Brambila, & Sigda, 2004; Landsman et al., 2001; Nickerson et
Based on a review of literature, Frensch and Cameron (2002) reported that “parental involvement and family support during treatment is consistently and significantly related to children and youths’ within-treatment progress and the ability to successfully adapt to the community following discharge” (p. 334). Mincey and colleagues (2008) reported that juvenile offenders whose families were supportive during their treatment were less likely to re-offend. According to some, however, many residential treatment programs rarely involve parents and families as active participants (Knecht & Hargrave, 2002; Nickerson et al., 2004). Some parents reported that no RTC staff had asked them what treatment goals would be appropriate for their children (Demmitt & Joanning, 1998). Thus, involvement of parents and families sometimes happens only because they make sure that they are included in the youth’s treatment (Kruzich, Friesen, Williams-Murphy, & Longley, 2002). Furthermore, the issue of how RTC administrators and staff work with families to facilitate the adolescent’s transition home has not been researched as much as needed (Nickerson et al., 2007). Yet another issue that appears to be lacking in the literature is whether there are negative aspects to having families involved in residential treatment.

Efforts are being made to increase families’ involvement in residential treatment (Fairhurst, 1996; Knecht & Hargrave, 2002; Nickerson et al., 2006). Nickerson and colleagues (2006) reported that in a recent study that focused on a population from an RTC in suburban upstate New York, phone calls were the most frequently occurring contact. This study also showed that families visited adolescents in the residential treatment facility and made efforts to contact and meet with staff members (Nickerson et
Family Involvement in Residential Treatment Therapy

As demonstrated, efforts are being made to involve families generally in their adolescents’ residential treatment. Although the research reflects it much less, it appears that families are also involved in RTC therapy for their adolescents. Involvement in therapy involves a family member is actually participating in scheduled therapy sessions with the adolescent and his/her therapist. A recent study by Baker and colleagues (2008) revealed that among 37 RTCs in New York State, 73% were offering the vast majority of their families the opportunity to participate in family therapy with their adolescents. They also reported that two factors that limited family involvement were family resistance to participation and practical constraints on participating (Baker et al., 2008).

In an older study (Springer & Stahmann, 1998), telephone family therapy was used to involve families in therapy. The families viewed this approach as an effective way to be involved with their adolescents’ therapy (Springer & Stahmann, 1998). Parents have reported that family therapy is helpful in preparing the adolescents and their families for other elements of treatment, such as adolescents’ home visits (Demmitt & Joanning, 1998).

The use of family therapy in residential treatment has been shown to increase the likelihood that positive outcomes will be reached. Stage (1999) reported that among 130 adolescents who had completed residential treatment that involved family therapy, 95% of females and 82% of males had been discharged to their parents, a relative, or a group
home with a less restrictive setting, as opposed to being discharged to a more restrictive setting such as a juvenile detention facility. Lakin and colleagues (2004) demonstrated that those adolescents whose parents consistently called, visited, took their adolescents on planned therapeutic absences, and participated in weekly family therapy sessions had better prognoses of maintaining therapeutic gains in the community. It should be noted, however, that the degree to which family-oriented treatments lead to positive outcomes for child problems varies depending on the types of problems that the children have and the specific types of treatments that are used (Lakin et al., 2004). Parents have echoed a desire for effective and skillful therapy in cases where family therapy is included as part of adolescents’ residential treatment (Demmitt & Joanning, 1998).

According to Mincey and colleagues (2008), adolescents who had successfully graduated from residential programs in Florida reported that overcoming negative behavior was challenging due to facing circumstances after treatment that were similar to those before treatment, such as family dynamics. In a similar vein, Nickerson and colleagues (2004) suggested that what happens with the adolescents outside of the RTC may be even more important than what happens with them inside. If this truly is the case, then family involvement in therapy takes on greater importance because the changes that are introduced in therapy can be better applied when the family is a part of those therapeutic changes. Crenshaw and Foreacre (2001) suggested that a combination of individual and family therapy would likely speed up treatment progress because, during individual therapy, the adolescent would be able to address and practice responses to
what may come up in family therapy and then put the plan into action during family therapy sessions.

Opinions of RTC Staff and Families

Although efforts are being made to include families in their children’s residential treatment, there can be differences in perception of the family’s involvement between the RTC staff members, the families, and the adolescents. In one study (Nickerson et al., 2006), interviews were conducted with 21 residential treatment staff members, 20 adolescents in residential treatment, and the adolescents’ parents or guardians (21 participants in this group. Each group’s interview was designed to “examine strengths, family involvement, and transition planning for adolescents in residential treatment” (Nickerson et al., 2006, p. 76). All three groups were of the opinion that more work with families was needed in residential treatment (Nickerson et al., 2006). However, there were many more differences in responses between the three groups than there were similarities (Nickerson et al., 2006). For example, staff members were significantly more concerned about all areas of the adolescents’ lives following termination of residential treatment than were the adolescents and their parents (e.g., getting along with family once the adolescent returned home; Nickerson et al., 2006). Limitations of this study include the fact that it was conducted at only one RTC and that the sample was small (Nickerson et al., 2006). The results of this study demonstrate that a construct such as family involvement is made more complex in measurement due to these differences in opinion among the various individuals involved and therefore deserves further exploration.
Rationale for this Study

Research has demonstrated that family involvement in residential treatment and therapy leads to more positive outcomes during and after treatment. It has also demonstrated that efforts are being made currently to include families in various elements of adolescents’ residential treatment, including RTC therapy. However, the literature does not demonstrate whether the individuals involved in adolescent residential treatment (such as agency administrators, therapists, family members, and the adolescents) agree regarding the level to which families are and should be involved in treatment. Given the importance of involving an adolescent’s family in his or her residential treatment as it relates to positive outcomes, a crucial next step would be to determine whether the therapists and the families of the adolescents with whom they work agree regarding the level of involvement of those families in all aspects of the adolescents’ residential treatment. The current study was designed to offer research that addresses that step. This study also allowed participants to report any positive, neutral, and negative aspects they perceived in having families involved in residential treatment.

Purpose and Research Questions

The purpose of this study was to investigate therapists’ and family members’ perceptions of and opinions regarding the extent to which families are and should be involved in residential treatment and therapy.

The specific questions in this study include:
1. How do families and therapists describe family involvement in residential treatment and therapy?

2. What are similarities and differences between therapists’ and family members’ perceptions regarding family involvement in residential treatment and therapy?

3. What recommendations do therapists and family members have for family involvement in residential treatment and therapy?
CHAPTER III

METHOD

Design

This study used a descriptive design. I surveyed therapist and family participants about their opinions on family involvement in adolescent residential treatment. The survey was designed to shed light on therapists’ and families’ perceptions of therapy; differences of opinion, if any, between therapists and families regarding the study topic; and recommendations that therapists and families have for including families in the treatment of adolescents in residential care. Participants were recruited from six facilities in order to examine potential differences among a diversity of residential centers. The data were gathered through both paper and online questionnaires to allow participants to fill out the questionnaires in the way that would be easiest for them. All questionnaires were coded so that (a) participants could be matched with therapists and/or treatment centers and (b) participation could be anonymous.

Sample

The participants in this research project included therapists and family members of adolescent residents in six residential treatment centers in Utah. The RTCs were selected using a number of criteria. First, the adolescent clients in the facilities ranged in age from 11 to 18 years old. Second, the administration and staff in these RTCs reported that they promote the involvement of the adolescents’ families in treatment. This
criterion was used so that participants’ responses could be reported based on the assumption that families were already involved and with the intent to find out how much and in what ways they were involved. Finally, administrators supported the study and therapists were willing to participate in the study and recruit family participants. See Table 1 for other information about the participating RTCs.

A diversity of participants was given the opportunity to participate in the study. Participation was sought from therapists and families involved in RTCs that were both privately and state funded, from three counties in Utah, had programs for both male and female adolescents with a variety of presenting clinical problems, and operated as in-house programs. Seven programs declined participation. Thus, the participating RTCs were not as diverse as was intended. Among the 6 participating RTCs, 4 programs housed only male adolescents and 2 programs housed both male and female adolescents. Three facilities treated adolescent sex offenders and the other three focused on areas that included behavioral problems, emotional problems, learning disabilities, and so forth.

The study used a convenience sample comprised of 89 individuals. The target number of therapist participants was 20; the actual number of therapist participants was 24, who reported demographic information such as age, sex, race, and license (see Table 2 for a summary of participants’ ages, grouped by type of participant and by sex). The average age of the therapist participants was 42 ($SD = 11$) with a range of 30 to 67 years. All but 1 therapist participant reported being Caucasian/White; that participant reported being White/Latino. Six participants indicated that they were licensed in professional counseling, 10 in marriage and family therapy, and 8 in social work. See Table 3 for a
Table 1

**Participating Residential Treatment Centers (N = 6)**

<table>
<thead>
<tr>
<th>RTC</th>
<th>State funded</th>
<th>Privately funded</th>
<th>Males</th>
<th>Females</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>X</td>
<td>—</td>
<td>X</td>
<td>—</td>
<td>Cache</td>
</tr>
<tr>
<td>B</td>
<td>X</td>
<td>—</td>
<td>X</td>
<td>—</td>
<td>Box Elder</td>
</tr>
<tr>
<td>C</td>
<td>—</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Cache</td>
</tr>
<tr>
<td>D</td>
<td>—</td>
<td>X</td>
<td>X</td>
<td>—</td>
<td>Utah</td>
</tr>
<tr>
<td>E</td>
<td>X</td>
<td>—</td>
<td>X</td>
<td>—</td>
<td>Utah</td>
</tr>
<tr>
<td>F</td>
<td>—</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Utah</td>
</tr>
</tbody>
</table>

a description of the therapist sample by RTC.

The target number of family participants was 60; the actual number of family participants was 64. Those 64 individuals represented 55 different families. There were

Table 2

**Age of Participant by Sex (n = 86)**

<table>
<thead>
<tr>
<th>Participant group</th>
<th>Male (n = 41)</th>
<th>Female (n = 45)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>M (SD)</td>
</tr>
<tr>
<td>Therapists</td>
<td>17</td>
<td>40 (11)</td>
</tr>
<tr>
<td>Family members</td>
<td>24</td>
<td>52 (9)</td>
</tr>
<tr>
<td>Total sample</td>
<td>41</td>
<td>48 (12)</td>
</tr>
</tbody>
</table>

*Note.* Missing cases = 3.
4 online questionnaires submitted by family participants that contained incorrect codes; the format did not match coding requirements. Thus, as is illustrated in Table 4, the treatment centers and therapists with whom these 4 participants were affiliated was unknown. These data were used for all reports except the direct comparisons between responses of therapists and family members that were meeting together in therapy (Research Question #2). There was also one questionnaire submitted by two family participants: one couple filled out a questionnaire together. The data from these participants were treated as data from two participants as if the couple had submitted separate questionnaires.

The average age of the 64 family participants was 50 (SD = 10) and the age range

Table 3

*Therapist Participant Demographics by Treatment Center (n = 24)*

<table>
<thead>
<tr>
<th>RTC</th>
<th>Male</th>
<th>Female</th>
<th>White</th>
<th>Other</th>
<th>Counseling</th>
<th>MFT</th>
<th>Social Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>B</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>C</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>D</td>
<td>7</td>
<td>2</td>
<td>9</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>E</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>F</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>7</td>
<td>23</td>
<td>1</td>
<td>6</td>
<td>10</td>
<td>8</td>
</tr>
</tbody>
</table>
Table 4

*Participant Response Rates by Treatment Center*

<table>
<thead>
<tr>
<th>RTC</th>
<th>Therapists</th>
<th>Families</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Volunteered</td>
<td>Submitted surveys</td>
</tr>
<tr>
<td>A</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>B</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>C</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>D</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>E</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>F</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Unknown</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>24</td>
</tr>
</tbody>
</table>

was 27 to 80 (see Table 5 for family participant demographics). Regarding race, 61 indicated they were Caucasian/White, 2 Hispanic/Latino, and 1 Asian. Of the 55 families represented, 6 did not report income. The majority of the families who provided income figures reported having a total income of over $100,000. All of these were families of adolescents in privately funded centers.

Based on the family participants’ responses, 12 families resided in the state of Utah, 39 families lived in other U.S. states, 1 family lived outside the US, and 3 families indicated that they were not from the state of Utah, but did not specify where they were living. Some adolescents had two families that submitted surveys (e.g., an adolescent
Table 5

*Family Participant Demographics (n = 64)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>25 (39%)</td>
</tr>
<tr>
<td>Women</td>
<td>39 (61%)</td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>61 (95%)</td>
</tr>
<tr>
<td>Other</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>Home</td>
<td></td>
</tr>
<tr>
<td>Utah</td>
<td>12 (22%)</td>
</tr>
<tr>
<td>Other</td>
<td>43 (78%)</td>
</tr>
<tr>
<td>Income</td>
<td></td>
</tr>
<tr>
<td>&lt;$50k</td>
<td>7 (15%)</td>
</tr>
<tr>
<td>$50 - $100k</td>
<td>14 (30%)</td>
</tr>
<tr>
<td>&gt;$100k</td>
<td>25 (54%)</td>
</tr>
</tbody>
</table>

*Note.* Questionnaires with no responses for income were not included in this report.

With divorced biological parents. In such cases, they were treated as two families for reporting data such as location of family’s home and family income. The only report that was made without these data was that of age, since it was unclear which person was what age.
The family participants were also asked how many individuals were living in the families’ households (see Table 6). These data were described by family because some family participants were living in the same household. In all cases but one where more than one person from the same family submitted a questionnaire, reports were consistent. That case was left out of this description. The most frequently endorsed family sizes were 3 and 4 at 14 apiece; 8 others endorsed a family size of 2. No reported number was greater than 9 individuals. One participant did not report family size.

**Adolescent Demographics**

Both the therapists and the family members were asked about adolescent demographics. These data are presented separately, since the therapists and family members were each reporting on a different number of adolescents. Participants were asked about the sex of the adolescent in treatment. Of the 107 adolescents about which

<table>
<thead>
<tr>
<th>Individuals</th>
<th>Freq.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>11</td>
<td>21%</td>
</tr>
<tr>
<td>3-4</td>
<td>28</td>
<td>53%</td>
</tr>
<tr>
<td>5-6</td>
<td>11</td>
<td>21%</td>
</tr>
<tr>
<td>7-8</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
therapist participants reported, 89 were male, 17 were female, and 1 adolescent’s sex was not reported. Of the 55 families, 44 indicated that their adolescents in treatment were male, 9 female, and 2 did not respond to the item. As indicated in Table 7, the average adolescent age as reported by therapists was $15.85 \text{ (SD = 1.30)}$ with a range of 13 to 18. Based on family members’ reports, the average age was $15.97 \text{ (SD = 1.28)}$ with a range of 13 to 18. Only family members were asked about the race of the adolescents in treatment. All adolescents for whom race was reported were Caucasian/White. Four family participants did not report adolescent race.

Therapist and family participants reported the length of time that each adolescent had been in therapy. There were differences between therapists’ and family members’ responses in the reported duration of therapy for some adolescents. Both therapists’ and family members’ responses are reported in Table 8.

The number of adolescents about which the therapists reported is different from that of the family participants because the therapists reported on all adolescents in their

| Table 7 |

*Age of Adolescent by Sex*

<table>
<thead>
<tr>
<th>Sex</th>
<th>Therapists</th>
<th>Family Members</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of adolescents</td>
<td>$M \text{ (SD)}$</td>
</tr>
<tr>
<td>Male</td>
<td>89</td>
<td>15.76 (1.33)</td>
</tr>
<tr>
<td>Female</td>
<td>17</td>
<td>16.29 (1.05)</td>
</tr>
<tr>
<td>Overall</td>
<td>106</td>
<td>15.85 (1.30)</td>
</tr>
</tbody>
</table>

*Note:* Questionnaires with no response to these items were not included in this analysis.
Table 8

Report of Adolescent Duration of Therapy by Group

<table>
<thead>
<tr>
<th>Duration</th>
<th>Therapist Report (n=105)</th>
<th>Family Report (n=60)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
</tr>
<tr>
<td>&lt;1 month</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>1 month</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>2</td>
<td>7</td>
<td>7%</td>
</tr>
<tr>
<td>3</td>
<td>14</td>
<td>13%</td>
</tr>
<tr>
<td>4</td>
<td>11</td>
<td>10%</td>
</tr>
<tr>
<td>5</td>
<td>10</td>
<td>10%</td>
</tr>
<tr>
<td>6</td>
<td>8</td>
<td>8%</td>
</tr>
<tr>
<td>7</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>8</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>9</td>
<td>5</td>
<td>5%</td>
</tr>
<tr>
<td>10</td>
<td>9</td>
<td>9%</td>
</tr>
<tr>
<td>11+</td>
<td>30</td>
<td>29%</td>
</tr>
</tbody>
</table>

Note. Questionnaires with no responses for this item were not included in this report.

caseloads, some whose families did not respond to the survey. The majority of the adolescents fell in the categories of three to six months and 11+ months.

Finally, all participants were asked about the presenting problems of the adolescents in treatment. The most common presenting problems reported were sex
offender, oppositional defiant disorder, attention deficit/hyperactivity disorder, depression, anxiety, substance abuse, poor school performance, pervasive development disorder, posttraumatic stress disorder, anger/rage, suicidal ideation, mood problems, attachment issues, learning/cognitive disorder, and obsessive-compulsive disorder.

**Comparison items on adolescent demographics.** There were several items from the questionnaire regarding demographics that could be directly compared between therapist and family participants’ responses such as the sex, age, number of months in therapy of the adolescent, and the location of the family’s residence. Questionnaires were compared if the therapist and the family were connected to the same adolescent in treatment; 59 pairs of therapist and family questionnaires were directly compared.

Of the 59 pairs of therapist and family responses, 56 pairs agreed on the sex of the adolescent, 1 pair disagreed, and 2 pairs were not compared because one or both did not respond to the item. Regarding the pair that disagreed, the therapist reported that the sex of the adolescent was female and the family participant reported that the adolescent was male.

Regarding comparison of adolescent age, 49 pairs agreed on the age of the adolescent, 1 pair disagreed with the therapist’s reporting a younger age than the family participant, 6 pairs disagreed with the family members’ reporting a younger age, and 3 pairs were not compared because at least one participant did not respond to the item.

The item about duration of therapy stated, “Number of months adolescent has been in therapy (please circle one).” The participants had the option of selecting any one of the numbers <1 up to 11+. Of those surveys that could be directly compared, 34 pairs
agreed regarding the number of months the adolescent had been in therapy, 12 pairs disagreed with the therapists’ reporting a smaller number, 11 disagreed with the family participants’ reporting a smaller number, and 2 pairs could not be compared because at least one participant did not respond to the item. Regarding the residence of the adolescent’s family, 43 pairs agreed, 5 pairs disagreed, and 11 pairs could not be compared because one or both participants did not respond to the item.

**Instruments**

Data were gathered through three self-designed questionnaires. These questionnaires were accessible online or as hard copy. The first questionnaire was designed for RTC therapists to provide general information about themselves and their opinions regarding ideal family involvement in residential treatment. This questionnaire included four demographic items about the therapists’ sex, age, race, and type of license in the mental health field. It also contained five multiple-option items about the therapists’ recommendations for different ways a family should be involved in residential treatment (letters/e-mails from family, phone calls from family, family visits to treatment center, adolescent visits home, and family therapy) and to what extent (for all items, 1 = Never, 2 = Once every 2-3 months, 3 = Once a month, 4 = Twice a month, and 5 = Once or more a week). Finally, this questionnaire contained two open-ended items so that therapists could provide clarifying information for any of their responses and any other comments (see Appendix C for all instruments).
The second therapist questionnaire was designed for therapist participants to provide information on each adolescent in their caseloads. The first three items were demographic items regarding the therapist, were redundant with items on the first therapist questionnaire, and could have been deleted. The next four items were about the adolescent: sex and age, presenting problem, and the number of months the adolescent had been in therapy. The next 11 items were multiple-option about the extent and ways in which the adolescent’s family was involved in treatment and about the means and frequency with which individual and family therapy was conducted (e.g., “In what ways is the family of the adolescent in residential treatment involved in his/her treatment?”). The options for the participants included letters, e-mails, phone calls, visits to the treatment center, participation in therapy, visits home by adolescent, and visits outside the center. This therapist questionnaire included two items about family therapy sessions, specifically, (a) how many times each month the therapist met with the adolescent and family members in scheduled family therapy sessions and (b) how long family therapy sessions lasted. Finally, two open-ended items were included for clarifying information regarding the adolescent or other information the therapists may have wanted to provide.

The third questionnaire was designed for the families of the adolescents in residential treatment. The first 12 items on the questionnaire asked about demographic information of the family member and the adolescent in treatment such as sex, age, race, location of the family’s home, the number of individuals living in the household, and the family’s income. The next 11 items were multiple-option items about the extent and ways in which the adolescent’s family was involved in treatment, the means and
frequency with which individual and family therapy was conducted, and recommendations for different ways a family should be involved in residential treatment and to what extent (same five items as the first therapist questionnaire). Finally, as with the therapists, the family participants had the opportunity to clarify any questionnaire responses or include any other comments.

Procedures

Pilot Study

Before conducting the study, approval was received from the USU Institutional Review Board (IRB) for the protection of human research participants. I conducted a pilot study with an administrator of two residential treatment centers. This pilot study was done to make sure that the plan of execution would work in a real-world setting such as a treatment center; data from the pilot study were used in all reports and analyses. The administrator arranged for me to meet with three therapists at the two centers, where I explained the study and asked them to fill out the therapist questionnaires. They provided feedback regarding the survey and the process of participating in the study. They did not, however, look at or provide feedback regarding the family questionnaire. The pilot study led to one major change in two items on both the family and the therapist questionnaires: on both questionnaires, the participants were asked (a) who in the adolescent’s family was involved in therapy and (b) who was most involved in therapy. Initially there were options that had two items combined as one (e.g., step/foster mother). I changed the options so that each was separate and distinct (e.g., stepmother, foster
mother; see Appendix C). An amendment was submitted to the IRB and the change was approved.

**Main Study**

The administrator from the pilot study provided contact information of other RTC administrators in Utah who might agree to participate and who worked at centers that fit the criteria for the study. I also contacted administrators who were referred by colleagues and by a neighbor. When I contacted the administrators, I explained to them the nature and purpose of the study and asked for permission to recruit therapists and families of the adolescents in their RTCs. Those administrators who agreed arranged for me to present the study to the therapists of the treatment center at staff meetings. Thirteen centers were contacted; seven centers declined participation directly or by not responding.

**Therapist participation.** At the staff meetings, I explained the purpose and procedures of the study. All therapists who volunteered their participation (see Table 3) were provided cover letters and Letters of Information about the study and given opportunities to ask questions (see Appendix B for cover letter and Letters of Information). The cover letter invited the participants to be a part of the study and described basic details about the study. The Letter of Information was an official IRB-approved document explaining the study and was signed by the researchers. Therapist participants were asked to fill out the first therapist questionnaire once and the second therapist questionnaire one time for each adolescent for whom they were the primary therapist. I gave the therapists time during the meeting to look over the questionnaires and ask questions.
Each participating therapist filled out a form on which they indicated whether they wanted to fill out the questionnaires online or as hard copy, how many adolescents they were working with, and how many family members older than 18 had at any time participated in therapy sessions for each adolescent (see Appendix A for the therapist form). Those therapists who requested online versions of the questionnaire provided their e-mail addresses so that I could send information that contained links for the two therapist questionnaires. A second e-mail was sent to the therapists several days after the first e-mail as a reminder, thanking those who had filled out the survey, and reminding others to do so. Questionnaires that were submitted online were routed to an online account of Survey Monkey (Survey Monkey, 2008), which could be accessed with a username and password known only by me.

Nineteen therapists submitted hard copy forms of the first therapist questionnaire and 5 submitted them electronically. Therapists submitted 91 hard copy forms of the second therapist questionnaire; 15 forms were submitted online. Family participants submitted 8 hard copies and 55 online questionnaires (one questionnaire was counted twice for data collection because the parents completed it together).

**Family participation.** Therapists were asked to invite all family members who (a) at any time participated in therapy sessions for the adolescents in treatment and (b) were 18 years of age or older at the time of the study. During on-site family therapy sessions, the therapists provided each family with a packet containing the materials and information they would need to participate. Each packet contained a cover letter, an IRB-approved Letter of Information, and questionnaires for all family members over 18 who
had participated in therapy according to therapists’ reports. Family participants completed the questionnaires contained in the packet, placed them in postage-paid envelopes, and sent them to me in the mail.

Families who did not meet with the therapist in face-to-face visits near the time of the study were invited to fill out the questionnaires via a link contained in an e-mail sent to the family by the therapist. I sent each therapist one e-mail for each family that would be invited to fill out the questionnaires online based on the information from the forms the therapists filled out in the staff meetings. These e-mails contained attachments of the cover letter and Letter of Information, as well as a link to the online questionnaire. They also contained the same number of unique codes as the number of family members the therapist had indicated were 18 years or older and had participated in therapy.

When the therapists received the e-mails from me, they forwarded them to the appropriate families based on the codes from the therapist questionnaire. For example, the therapist sent the first e-mail to family number one, who was matched to the RTC, the therapist, and adolescent number one. Each family received one e-mail that contained a number of unique codes, one for each family member who was eligible to fill out a questionnaire and family members were asked to each use one and only one code. Thus, correspondence to families was facilitated by the therapists and was not from the researchers. I sent a follow-up e-mail to therapists several days after the first e-mail as a reminder for the family participants.

All participants were given the contact information of both researchers. They were invited to contact the researchers if they had any questions about the study or the
questionnaires. One therapist participant contacted me by phone and two family participants contacted me by e-mail with questions about the study. The e-mail correspondence was destroyed once the data collection period was over.

Confidentiality. Confidentiality was maintained through several means. Each participant who filled out a questionnaire had a pre-assigned code that served to identify that participant with the adolescent’s therapist and treatment center or, in the case of the therapists, the treatment center.

The use of online questionnaires carries with it implications regarding confidentiality that are not present in paper-and-pencil questionnaires. In cases where information is being transmitted over the World Wide Web, it is impossible to ensure that this information is 100% secure. However, the electronic survey program that was used for this study, Survey Monkey, is sensitive to personal information. It involves the use of secure socket layer technology (SSLT) for information encryption (Survey Monkey, 2008), which maximizes security of information transmitted over the internet. Furthermore, data from online questionnaires were accessible with a username and password that was known only by me. Copies of questionnaires received through the mail were locked in a filing cabinet, which was contained in a locked room. Raw data were downloaded from Survey Monkey to a flash drive that was locked away. Data will be kept for seven years, after which all data will be destroyed. Thus, to the fullest extent possible, participants’ responses have been and will be kept secure and confidential.

Compensation. Potential for compensation was used in this study. Each individual who participated in the study had the opportunity to be included in drawings
for one of two $50 gift cards to Walmart. Those who wanted to be included in the
drawing filled out and mailed in postcards with their names and contact information,
which were not coded and thus could not be connected to data. All postcards were
collected and at the end of data collection, two were drawn from the group. The two
winners were contacted using the information they provided. Both winners indicated that
they wanted the gift cards mailed to them. Contact information and postcards were
destroyed.

Analyses

When any questionnaire was submitted, I checked its codes to ensure that none
were used more than once, thus providing some reliability that each participant filled out
one and only one questionnaire. Descriptive analyses were conducted on the data for this
study. There are two different parts to analysis of the data: (a) analysis of and
comparison between responses of all participants to examine trends in responses to the
multiple-option items, and (b) determination of themes and trends in content from the
open-question responses. Some comparisons were made between participants based on
their RTC association in order to highlight similarities and differences. Reports of data
for each of the three research questions included applicable comments from participants’
questionnaires.
Research Question #1: How Do Families and Therapists Describe Family Involvement in Residential Treatment and Therapy?

For the first research question, I tallied and compared descriptive data from one questionnaire item about family involvement in general and four items about family involvement in therapy. Data from all participants who responded to these items were included in the analysis, independent of whether they were a therapist participant or family participant. Results are reported in text and tabular form.

Research Question #2: What Are Similarities and Differences Between Therapists’ and Family Members’ Perceptions Regarding Family Involvement in Residential Treatment and Therapy?

There were two types of analyses performed for this research question. First, participants’ responses to the questionnaire item about the different ways families were involved in the treatment process were compared by participant group (therapist and family). This analysis highlighted differences and similarities of how the therapist and family participants responded to this item. The second type of analysis involved making direct comparisons between therapists’ and family participants’ responses to determine whether they agreed. For this analysis, I included responses only from those participants who were working together on behalf of the adolescent in treatment. Data from those who did not have a corresponding participant with whom they could be compared were not included. That is, only if a therapist filled out a questionnaire on a particular
adolescent and a family member of the adolescent also filled out a questionnaire were responses compared.

**Research Question #3: What Recommendations Do Therapists and Family Members Have for Family Involvement in Residential Treatment and Therapy?**

Analysis for the third research question involved data from five multiple-option items that were included in both the therapists’ and family participants’ questionnaires. These items were identical for all participants and the response options from which participants could choose were uniform for all five items. Frequencies were calculated for each item based on how the participants responded and those frequencies were compared between therapist and family groups.
CHAPTER IV
RESULTS

The data received from the therapists and family participants who filled out questionnaires include both quantitative and qualitative information. Responses for several items followed a multiple-option format, allowing for categorical description, such as frequencies of the thoughts and opinions of the therapists and family members. Other questionnaire items allowed the participants to offer individual comments in open items so that they could elaborate and comment on items. Below is a summary of analyses of the data for each research question.

Research Question #1: How Do Families and Therapists Describe Family Involvement in Residential Treatment and Therapy?

Types of Family Involvement

Data were gathered from therapist and family participants to describe family involvement in residential treatment and therapy. One questionnaire item contained a list of seven different ways in which families have been shown to be involved based on the literature of family involvement in residential treatment. Each participant was asked to endorse all options that the families of the adolescents had used in their efforts to be involved in treatment. All therapist and family participants who submitted questionnaires (N = 88) selected at least one of the seven options from this item on the survey. As noted earlier, therapist participants were asked to fill out the second questionnaire as many times as they needed for each adolescent in their caseloads, but not all of the adolescents’
families had members who responded. Thus, there were more questionnaires submitted by therapists than there were family participants in the study. See Table 9 for frequencies of selection for each option.

Based on evaluation of all participants’ surveys, the most commonly reported form of involvement from the families of the adolescents in treatment was phone calls. Ninety-six percent of all participants indicated that the families were using phone calls to stay involved.

According to all participants, the second most frequently reported form of family involvement was the families’ participation in therapy. Ninety-four percent of all participants indicated that participation in therapy was a way in which the families were involved in treatment. The least commonly used form of family involvement was visits

Table 9

*Endorsed Types of Family Involvement in Residential Treatment, Total Sample (N = 88)*

<table>
<thead>
<tr>
<th>Involvement type</th>
<th>Freq.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone calls</td>
<td>163</td>
<td>96%</td>
</tr>
<tr>
<td>Participation in therapy</td>
<td>160</td>
<td>94%</td>
</tr>
<tr>
<td>Visits to treatment center</td>
<td>145</td>
<td>85%</td>
</tr>
<tr>
<td>Letters</td>
<td>132</td>
<td>78%</td>
</tr>
<tr>
<td>Visits outside center</td>
<td>108</td>
<td>64%</td>
</tr>
<tr>
<td>E-mails</td>
<td>106</td>
<td>62%</td>
</tr>
<tr>
<td>Visits home by adolescent</td>
<td>78</td>
<td>46%</td>
</tr>
</tbody>
</table>
home by the adolescent; this was the only option that was selected by fewer than half the participants.

There were several comments from participants that described how families determined in what ways and how much they should be involved. One therapist participant said, “The process that the students go through in residential some require weekly calls & letters & some don’t. I believe that sometimes parents can over communicate & smother their kids—the same of some students.” Another therapist said, “Family involvement depends on the family’s overall functioning. If family contact distracts because of instability, drug abuse, etc. it can be detrimental to the youth’s progress.”

One family participant had this to say: “Initially, we felt we should not make much contact with our [child], and the treatment center felt the same way.” Several comments followed a theme that family involvement was different depending upon the adolescent’s and family’s circumstances. One family participant said, “E-mails would be ideal, however, in my experience the child does not have access to computer, or e-mail. I answered my questions due to proximity of the group home. 1.5 hour drive one way affects my specific answers.” Another family participant commented, “The question of phone calls, visits, letters, and how much family should participate in therapy depends a great deal on the individual case. In ours, all of these things changed as the condition of our [child] changed.” A different family participant said, “My answers, particularly about the frequencies of contact (e-mails, phone calls, and visits) reflect our particular set
of circumstances. Having said that, it’s hard to imagine any benefit arising from excluding the family from their child’s treatment.”

**Family Involvement in Therapy**

Each participant was asked whether anyone from the adolescent’s immediate family was involved in therapy with the adolescent. This refers to family members “sitting in” with the adolescent and the therapist for sessions of therapy that would otherwise be conducted with only the therapist and the adolescent (individual therapy). Of the 170 questionnaires returned, 86% \((n = 147)\) reported that someone from the immediate family was involved in therapy, 12% \((n = 20)\) reported that no one from the immediate family was involved in therapy, and 2% \((n = 3)\) did not respond to the item. Results of comparisons between therapists and family members are reported in Research Question #2.

The therapists’ questionnaires about specific adolescents in their caseloads contained two items about family therapy sessions. One item asked how many times each month the therapist typically met with the adolescent and family members in scheduled family therapy sessions. Therapists reported an average of 4.18 scheduled sessions per month \((SD = 1.36)\), with a range between 1 and 8 sessions. See Table 10 for number of scheduled family therapy sessions by treatment center.

The second item asked about the duration of family therapy sessions. The most commonly reported duration of family therapy sessions was 60 minutes. The second most common was 90 minutes. Those two responses together accounted for 55% of responses to this item. See Table 11 for frequencies of family therapy session duration.
Table 10

*Therapists’ Report of Number of Scheduled Family Therapy Sessions Per Month*

<table>
<thead>
<tr>
<th>RTC</th>
<th>Number of adolescents</th>
<th>M</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>7</td>
<td>2.14</td>
<td>0.90</td>
<td>1-3</td>
</tr>
<tr>
<td>B</td>
<td>8</td>
<td>4.88</td>
<td>1.64</td>
<td>3-8</td>
</tr>
<tr>
<td>C</td>
<td>21</td>
<td>4.38</td>
<td>1.20</td>
<td>4-8</td>
</tr>
<tr>
<td>D</td>
<td>41</td>
<td>4.12</td>
<td>0.64</td>
<td>4-8</td>
</tr>
<tr>
<td>E</td>
<td>4</td>
<td>1.75</td>
<td>0.50</td>
<td>1-2</td>
</tr>
<tr>
<td>F</td>
<td>26</td>
<td>4.81</td>
<td>1.52</td>
<td>4-8</td>
</tr>
<tr>
<td>Overall</td>
<td>107</td>
<td>4.18</td>
<td>1.36</td>
<td>1-8</td>
</tr>
</tbody>
</table>

There was also an item on the questionnaire about the ways in which therapy sessions involving family members were conducted. Participants were given four options on this item: in person, telephone conference call, internet video, and other. Participants were asked to endorse all options that were applicable to them. Both therapists’ and family participants’ questionnaires included this item. As displayed in Table 12, the most popular mode of family therapy reported by both therapist and family participants was telephone conference calls, followed closely by sessions in person. Eleven therapist participants and one family participant did not respond to this item.
Table 11

*Therapists’ Report of Duration of Family Therapy Sessions*

<table>
<thead>
<tr>
<th>Duration</th>
<th>Freq.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20 min.</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>20 min.</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>30 min.</td>
<td>16</td>
<td>15%</td>
</tr>
<tr>
<td>40 min.</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>50 min.</td>
<td>11</td>
<td>10%</td>
</tr>
<tr>
<td>60 min.</td>
<td>34</td>
<td>32%</td>
</tr>
<tr>
<td>70 min.</td>
<td>13</td>
<td>12%</td>
</tr>
<tr>
<td>80 min.</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>90 min.</td>
<td>25</td>
<td>23%</td>
</tr>
<tr>
<td>100+ min.</td>
<td>1</td>
<td>1%</td>
</tr>
</tbody>
</table>

**Participants’ Comments About Family Involvement in Therapy**

Regarding family involvement in therapy, one therapist commented, “Sometimes parents need to do their own work to get ready for the child to return home—much of the time the child should not be in that session.” A family participant said, “It’s very important that parents be closely involved in therapy, but also must allow the therapist to direct the process.” One family participant described his involvement in therapy this way:
Table 12
Participants’ Endorsements of Modes of Therapy Sessions Involving Family Members

<table>
<thead>
<tr>
<th>Option</th>
<th>Therapists (n = 24)</th>
<th>Family members (n = 62)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
</tr>
<tr>
<td>In person</td>
<td>74</td>
<td>77%</td>
</tr>
<tr>
<td>Telephone</td>
<td>88</td>
<td>92%</td>
</tr>
<tr>
<td>Internet</td>
<td>10</td>
<td>10%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Missing</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

I am the . . . [parent] of the adolescent, but have little involvement in . . . therapy, I guess because [my adolescent] was enrolled there by [other family members] when they were his limited guardians, I feel I should have some say as to what kind of therapy [my adolescent] is receiving.

Another family participant said, “My [child] has been in two different facilities in the state and the second one has involved me more in the therapy and I have found that very helpful to me and beneficial to my [child].”

**Family Member Most Involved in Therapy**

Regarding family involvement in therapy, I was interested to know the relationships to the adolescent of family members that were most involved in therapy. There were a number of different types of family members involved the most in therapy as reported by therapists and family members. The vast majority of therapist and family
participants who answered this item ($n = 147; 94\%$) reported that those most involved were the adolescents’ parents, whether biological, adoptive, step-, or foster parents.

Forty-six percent of those participants who answered this item indicated that the mother was the most involved in therapy, including biological, adoptive, step-, or foster mother.

Ten participants (6\%) reported that someone other than the adolescents’ parents was most involved in therapy. Those who were most involved but were not parents were grandparents or aunts and uncles. Two participants answered this item with a combination of participants that included parents and non-parents (e.g., mother and grandmother). Thirteen participants did not respond to this item, most of whom indicated that no family members were involved in the therapy process. See Table 13 for breakdown of family members most involved in therapy.

Table 13

*Frequencies of Family Member Most Involved in Therapy, Total Sample (N = 88)*

<table>
<thead>
<tr>
<th>Family member</th>
<th>Freq.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>72</td>
<td>46%</td>
</tr>
<tr>
<td>Father</td>
<td>30</td>
<td>19%</td>
</tr>
<tr>
<td>Both parents</td>
<td>43</td>
<td>27%</td>
</tr>
<tr>
<td>Grandparent</td>
<td>6</td>
<td>4%</td>
</tr>
<tr>
<td>Aunt/Uncle</td>
<td>4</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1%</td>
</tr>
</tbody>
</table>
Research Question #2: What Are Similarities and Differences Between Therapists’ and Family Members’ Perceptions Regarding Family Involvement in Residential Treatment and Therapy?

Overall Comparisons

Reports on the ways in which families were involved generally in residential treatment were reported above. Those results were based on analysis of therapists’ and families’ data as a whole. Results of analyses for the current research question compare therapists’ responses to those of corresponding family participants. The frequencies for the types of family involvement differed depending on the group that was responding. The therapists reported that the most common form of family involvement was participation in therapy (99%), while the family group’s most frequent response was phone calls (98%). The second most frequent form of family involvement according to the therapists was phone calls (94%); according to the family members, the second most frequent contact came through family visits to the treatment center (89%). The third most common type of involvement was reported by the therapists as family visits to the center (83%), and by families as participation in therapy (86%). According to all groups (collective, therapist, and family), the least common form of family involvement was visits home by the adolescent in treatment (see Table 14 for display of results).

Regarding the two most endorsed forms of involvement in treatment—phone calls and therapy—therapist participants reported that 94% \((n = 101)\) of families of their adolescent clients had used phone calls as a form of involvement in treatment. Sixty three different family participants representing 55 adolescent residents submitted
responses to the item about the type of involvement for families, 98% \((n = 62)\) of whom indicated that they had used phone calls to be involved. Although therapists reported that 99% \((106)\) of all families of adolescents in their care had participated in therapy, 86% \((n = 54)\) of family participants indicated that they had participated in therapy. See Table 14 for a list of the frequencies and percentages of each of the forms of family involvement by type of participant.

**Direct Comparisons Between Therapist and Family Participants**

Therapist and family participants were matched based on the codes assigned to each participant. For this analysis, if a therapist participant was working with the

<table>
<thead>
<tr>
<th>Type of involvement reported</th>
<th>Therapists ((n = 24))</th>
<th>Family members ((n = 63))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in therapy</td>
<td>106  99%</td>
<td>54  86%</td>
</tr>
<tr>
<td>Phone calls</td>
<td>101  94%</td>
<td>62  98%</td>
</tr>
<tr>
<td>Visits to treatment center</td>
<td>89  83%</td>
<td>56  89%</td>
</tr>
<tr>
<td>Letters</td>
<td>82  77%</td>
<td>50  79%</td>
</tr>
<tr>
<td>Visits outside center</td>
<td>69  64%</td>
<td>39  62%</td>
</tr>
<tr>
<td>E-mails</td>
<td>61  57%</td>
<td>45  71%</td>
</tr>
<tr>
<td>Visits home by adolescent</td>
<td>46  43%</td>
<td>32  51%</td>
</tr>
</tbody>
</table>

*Note.* 107 families reported by therapists. Questionnaires with no responses for this item were not included in these analyses.
adolescent of a family participant, questionnaires were compared to determine how closely they agreed regarding family involvement. In cases where more than one family member submitted questionnaires, separate comparisons were made because the family participants’ responses often were different from one another. In other cases where therapists did not have any family participants submit questionnaires, those therapist responses were not included in these analyses. There were 59 pairs of surveys that were directly compared representing 45 adolescents.

Frequencies were computed for different ways in which families were involved. Each participant was asked to endorse as many options as were applicable to the adolescent’s family (letters, e-mails, phone calls, visits to treatment centers, participation in therapy, visits home by adolescent, and visits outside the center). This comparison was based on who endorsed each option from the questionnaire item. See Table 15 for frequencies and percentages of endorsements by both groups.

As illustrated in Table 15, regarding cases where both therapist and family participants endorsed an option, the highest rate of agreement was phone calls at 95%. There were four options with a rate of agreement of 71% or higher. Agreement on the other three options were all between 40% and 50%. However, these same three options had the highest rate of agreement with neither therapist nor family participant endorsing the option. The option with the highest rate of agreement (32%) with neither therapists’ nor family participants’ endorsements was adolescent home visits.

All cases but one where therapists and family members did not agree had a disagreement rate of 15% or lower. The only option with a higher percentage of
Table 15

Participants’ Endorsements of Ways Families Were Involved in Residential Treatment

<table>
<thead>
<tr>
<th>Option</th>
<th>Both endorsed</th>
<th>Neither endorsed</th>
<th>Therapist only</th>
<th>Family only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
<td>Freq.</td>
<td>%</td>
</tr>
<tr>
<td>Letters</td>
<td>42</td>
<td>71%</td>
<td>6</td>
<td>10%</td>
</tr>
<tr>
<td>E-mails</td>
<td>25</td>
<td>42%</td>
<td>8</td>
<td>14%</td>
</tr>
<tr>
<td>Phone</td>
<td>56</td>
<td>95%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Family visits</td>
<td>48</td>
<td>81%</td>
<td>2</td>
<td>3%</td>
</tr>
<tr>
<td>Therapy</td>
<td>51</td>
<td>86%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Home visits</td>
<td>28</td>
<td>47%</td>
<td>19</td>
<td>32%</td>
</tr>
<tr>
<td>Outside visits</td>
<td>29</td>
<td>49%</td>
<td>13</td>
<td>22%</td>
</tr>
</tbody>
</table>

Disagreement (32%) was family participants’ endorsing and therapist participants’ not endorsing the e-mail option.

Participants were asked about family involvement in therapy as separate from other forms of involvement in overall treatment. For this particular item the participants were asked to indicate whether the family had been involved in therapy sessions at all. Of the 59 pairs of compared responses, 46 pairs agreed on this item; 5 pairs disagreed with the therapists’ marking, “yes” and the family participants’ marking, “no”; 6 disagreed with the therapists’ marking, “no” and the family participants’ marking, “yes”; and 1 pair was not compared because one participant did not respond.
There was a separate item about how often any family member was involved in therapy with the adolescent. This item had only five options for endorsing. Ten pairs endorsed the same option, 27 pairs disagreed with the therapists’ giving a lower rating (lower rating means less involved in therapy), 21 pairs disagreed with the family participants’ giving a lower rating, and 1 pair was not compared because one participant did not respond. For the pairs who disagreed and the therapists gave a lower rating, the average difference between the therapists’ answers and the family participants’ answer was 2 (e.g., if the therapist marked ‘2,’ saying that the family was involved in therapy “Some of the time,” the family might have marked ‘4,’ saying they were involved “Most of the time”). For the pairs who disagreed and the families selected a lower rating, the average difference between responses was 1.6.

**Research Question #3: What Recommendations Do Therapists and Family Members Have for Family Involvement in Residential Treatment and Therapy?**

There were five items in both the therapist and family questionnaires that asked the participants’ opinions about what they considered ideal family involvement in adolescent residential treatment and therapy. For each item, the participants were asked to select one of five options: never, once every two to three months, once a month, twice a month, and once or more a week. See Table 16 for a summary of the frequency of responses among therapists as a group, family participants as a group, and all participants as a whole.
As shown in Table 16, the item that had the highest amount of endorsement for a frequency of once or more a week was phone calls. Thus, according to therapist and family participants as separate groups and as a whole, involvement in the form of frequent phone calls was most highly recommended. Similarly, there were three items that had no participants’ endorsements of “Never”: letters/e-mails, phone calls, family therapy. This means that these three forms of involvement are recommended to at least some degree of frequency by all participants.

The item that was recommended with the least amount of frequency overall was adolescent visits home, followed closely by family visits to the treatment center. More than 53% of each group endorsed “Once every 2-3 months” for adolescent visits home.

**Participant Comments About Recommendations for Family Involvement**

Some participants clarified their endorsements for items on recommendations. Regarding recommendations for frequency of adolescent visits home, one therapist said that his/her endorsed option “depends on distance family lives from RTC and family financial circumstances. Monthly would be great if possible.” Similarly, another therapist said that his/her recommendations “depend a lot on distance between [families’] home and the facility.” Regarding adolescent home visits and family’s participation in therapy, one family participant said, “Frequency should increase as adolescent approached discharge to home.”
Table 16

*Frequency of Therapists’ and Families’ Responses Regarding Recommended Family Involvement (N = 88)*

<table>
<thead>
<tr>
<th>Item</th>
<th>Never</th>
<th>Every 2-3 mo</th>
<th>Once/mo</th>
<th>Twice/mo</th>
<th>Once/week</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># resp</td>
<td>%</td>
<td># resp</td>
<td>%</td>
<td># resp</td>
</tr>
<tr>
<td>Letters/e-mails</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapists</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>1</td>
</tr>
<tr>
<td>Family members</td>
<td>0</td>
<td>0%</td>
<td>3</td>
<td>5%</td>
<td>7</td>
</tr>
<tr>
<td>All participants</td>
<td>0</td>
<td>0%</td>
<td>3</td>
<td>4%</td>
<td>8</td>
</tr>
<tr>
<td>Phone calls</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapists</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>Family members</td>
<td>0</td>
<td>0%</td>
<td>2</td>
<td>3%</td>
<td>1</td>
</tr>
<tr>
<td>All participants</td>
<td>0</td>
<td>0%</td>
<td>2</td>
<td>2%</td>
<td>1</td>
</tr>
<tr>
<td>Family visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapists</td>
<td>0</td>
<td>0%</td>
<td>11</td>
<td>46%</td>
<td>6</td>
</tr>
<tr>
<td>Family members</td>
<td>1</td>
<td>2%</td>
<td>35</td>
<td>56%</td>
<td>14</td>
</tr>
<tr>
<td>All participants</td>
<td>1</td>
<td>1%</td>
<td>45</td>
<td>52%</td>
<td>20</td>
</tr>
<tr>
<td>Home visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapists</td>
<td>0</td>
<td>0%</td>
<td>13</td>
<td>54%</td>
<td>5</td>
</tr>
<tr>
<td>Family members</td>
<td>2</td>
<td>3%</td>
<td>40</td>
<td>65%</td>
<td>11</td>
</tr>
<tr>
<td>All participants</td>
<td>2</td>
<td>2%</td>
<td>52</td>
<td>61%</td>
<td>16</td>
</tr>
</tbody>
</table>

*(table continues)*
One therapist said, “Parents’ involvement in therapy with each other at home, and with the adolescent by telephone and face to face during visits, is a critical aspect of effective residential treatment.” Another therapist suggested that “family sessions should always include all family members, but this is seldom practical in this setting.” One therapist suggested that “occasionally enmeshed family systems require firmer boundaries and less contact initially for insight and differentiation to begin.” One therapist recommended that there should be “both individual and family therapy in balanced amounts in general, though individual needs may necessitate changes in the ratio.”

Regarding family participants’ comments, one family participant said, “I believe that the families should be involved as treatment allows. It shows the unconditional love you have for your child.” Another simply said, “Weekly family therapy is important.” A third family participant stated, “Families must be involved or the treatment will not work.” This family participant was more specific:

<table>
<thead>
<tr>
<th>Item</th>
<th>Never</th>
<th>Every 2-3 mo</th>
<th>Once/mo</th>
<th>Twice/mo</th>
<th>Once/week</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># resp</td>
<td>%</td>
<td># resp</td>
<td>%</td>
<td># resp</td>
</tr>
<tr>
<td>Family therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapists</td>
<td>0</td>
<td>0%</td>
<td>3</td>
<td>14%</td>
<td>5</td>
</tr>
<tr>
<td>Family members</td>
<td>0</td>
<td>0%</td>
<td>14</td>
<td>22%</td>
<td>10</td>
</tr>
<tr>
<td>All participants</td>
<td>0</td>
<td>0%</td>
<td>17</td>
<td>20%</td>
<td>15</td>
</tr>
</tbody>
</table>
Phone calls, visits, e-mails/letters frequency should be based upon how the child is progressing. A child that blames his/her parents for their situation should not be in constant contact with them until they take ownership of their behavior. Sometimes distance from family and third party authority breaks a child’s cycle of bad choices.

Another family participant said this:

In order for the program to work, I feel that interaction with family members is important, but limited (except for occasional visits) until after the adolescent has accepted the program and has the desire to make appropriate changes. The phone sessions are good for therapy, as long as there is structure and goals to accomplish rather than chit-chat sessions. Parents should be informed of a structured plan for these calls in advance to help ensure they are productive.
CHAPTER V
DISCUSSION

The purpose of this study was to investigate therapists’ and family members’ perceptions of and opinions regarding the extent to which families are and should be involved in residential treatment and therapy. There are many different types of residential treatment centers for troubled adolescents and many different definitions of residential treatment (Butler & McPherson, 2007). Therefore, I sought participation in this study from many different RTCs. Although this was a small study of therapists and families from six RTCs, diversity of clinical populations served, sex of resident, and diversity of family demographics allowed reports of data to reveal a range of responses and ideas regarding family involvement in adolescent residential treatment.

As was requested when administrators were informed of this study, all families about which therapist and family participants reported were involved in their adolescents’ treatment in some way. This involvement varied by RTC, including families’ making phone calls to their adolescents, writing letters to their adolescents, visiting the treatment facility, participating in therapy, having home visits by the adolescents, or having visits with the adolescents outside the treatment center. Furthermore, therapist and family participants reported that family involvement in therapy was one of the top three priorities in terms of the ways in which the families were involved. Overall, the families appeared to be making efforts to be a part of their adolescents’ treatment to overcome or learn to live with their presenting problems. Thus, the facilities in this study would not
be categorized with those treatment centers that rarely involve parents and families as active participants (Knecht & Hargrave, 2002; Nickerson et al., 2004).

Among those adolescents about whom participants in this study reported, 29% from therapist reports and 39% from family member reports had been in therapy for 11 months or longer. The discrepancy of these percentages may, in part, be because there was a different number of adolescents reported on by each participant group. Most of the centers in this study follow traditional long-term treatment of one year or longer. Thus, although some programs have implemented a brief therapy approach to treatment (Leichtman et al., 2001), the centers involved in this study use treatment programs that take many months. This difference may also be accounted for in the types of presenting problems of the adolescents in these facilities; perhaps change and improvement for the presenting problems of the adolescents in some centers take longer than the presenting problems of adolescents at facilities that utilize a brief-therapy approach. Finally, “therapy” was not defined and participants may have had different ideas about what it meant: all kinds of therapy, including previous outpatient help, or time in the RTC only.

The following sections provide discussion of data analyses for each research question. This chapter also includes a discussion of recommendations for practice and further research as well as limitations of the study.
Research Question #1: How Do Families and Therapists Describe Family Involvement in Residential Treatment and Therapy?

Based on the results of the analyses and the comments from the therapists and the families in this study, the adolescents were not being treated in isolation from their families. The administration for each RTC claimed that they promoted family involvement in treatment; the results from this study verify that the administrators had an accurate picture of whether the families were involved in the treatment of their adolescents. These findings are consistent with the literature that treatment programs are making efforts to increase the level of family involvement in residential treatment (Fairhurst, 1996; Knecht & Hargrave, 2002; Nickerson et al., 2006).

Regarding the ways in which the families of this study were involved in treatment, every family participant and every family about which the therapist participants reported had used at least one of the seven forms of family involvement during the course of the adolescents’ treatment: letters, e-mails, phone calls, visits to the treatment center, participation in therapy, visits home by the adolescent, and visits outside the center. However, the frequency of each type of involvement was different, suggesting that families were limited in some ways, either by center requirements and limitations, preference, or other limitations such as distance from the center or limited access to technology. For example, in this study, phone calls were the most frequently occurring form of family contact reported, which is consistent with the same findings of Nickerson and colleagues (2006).
Therapists were asked to invite families to participate in this study based on the families’ participation in therapy. However, the inclusion of invitations from therapists to the families by e-mail seems to have led to an invitation from therapists to *all* families of the adolescents in their caseloads, based on the fact that some participants reported that no member of certain families was involved in therapy. It was clear that family involvement in therapy was indeed important to these participants, given that it was the second most popular form of family involvement endorsed by therapist and family participants collectively, more so than visits to and visits outside of treatment center, letters and e-mails from home, and visits home by the adolescent. Furthermore, each of the six RTCs offered and made efforts to involve families in the therapy process, a rate of 100%, compared to the rate of 73% of 37 RTCs in New York reported by Baker and colleagues (2008). The 100% rate for this study may be accounted for by the criterion for family participation that was explained to the administrators and therapists when they agreed to participate.

Multiple ways of involving families in therapy were reported by the therapists. The vast majority of the participants reported that family therapy had been conducted by telephone conference calls. These findings parallel those reported by Springer and Stahmann (1998).

Although the RTCs in this study facilitated a treatment process that involved the families in many ways, it appeared that at least some therapists and families recognized that there was a possibility of too much family involvement. For example, a family participant commented that “Initially, we felt we should not make much contact with our
son, and the treatment center felt the same way.” This family member and reportedly the treatment center seemed to feel that when this adolescent began treatment, too much family involvement could have been detrimental.

A common, recurring theme among the information from the family participants was that they described their involvement in various ways depending on their circumstances. These family participants said that their involvement would be different if their circumstances were different. Specifically, the family’s distance from the center, how long the adolescent had been in treatment, and how the adolescent was progressing in treatment were factors that family members reported affected the level to which the family was involved. There were likely other circumstances not specified that affected the families’ involvement, such as family members’ health, court orders, restrictions placed by case managers, and so forth (Larson, 2008). Thus, in residential treatment, families’ circumstances in some cases are conducive to being involved and in other cases, circumstances prevent families from being involved as much as they and perhaps therapists would like.

**Research Question #2: What Are Similarities and Differences Between Therapists’ and Family Members’ Perceptions Regarding Family Involvement in Residential Treatment and Therapy?**

Analysis of data for understanding similarities and differences between therapists’ and family members’ ideas about family involvement in residential treatment and therapy
focused on a direct comparison of matched responses for items on the questionnaire that were asked of both groups of participants.

**Similarities**

Analysis of the data produced results about the level of agreement between therapist and family participants regarding adolescent demographic information. Ninety-eight percent of comparisons regarding adolescent sex, 89% of comparisons regarding where the family lived, and 87% of comparisons regarding adolescent age were consistent between therapists’ and family members’ responses. This high level of agreement would indicate that the therapists were familiar with such demographics of the adolescents with whom they were working. This would be a necessary component for the therapist and adolescent to have the kind of therapeutic relationship conducive to change and improvement.

The responses of the participants regarding their perceptions of family involvement were similar in many respects. All participants—therapists and families—indicated in some way or another that the families of the adolescents were involved, if even in a small way, in the adolescents’ treatment. Regarding phone calls, for example, 94% of therapists and 98% of families reported that the families were using this medium as a way of being involved. Also, 77% of therapists and 79% of family participants reported that families were using letters to be involved.

Another example of agreement between the therapist and family participants was related to direct comparisons between the two groups’ responses. There were several areas for which both the therapists and families indicated the specific families were
involved. For example, regarding phone calls (95%), therapy sessions (88%), and family visits to the treatment center (81%), the rate of agreement for endorsement was over 80%.

These examples of agreement demonstrate that therapist and family participants had similar perceptions of how the families were involved. Such similarities would indicate that their reports are reliable and that therapists, families, and adolescents communicate these things to each other.

**Differences**

One of the differences between the responses of the therapists and those of the family members was the order of the most popular forms of family involvement. For therapist participants, the most frequently endorsed form of family involvement was involvement in therapy, followed by phone calls to the adolescent, then family visits to the treatment center. For family participants, the most frequently endorsed form of family involvement was phone calls, then visits to the treatment center, and finally participation in therapy. The top three endorsed options for this questionnaire item were the same between therapist and family participants, despite the difference in order. These differences may indicate that some reports of how families were involved were inaccurate or that communication was not 100% reliable among the parties. The fact that the therapists reported that 99% of the families were involved in therapy would indicate that family involvement in therapy was something that most if not all therapists facilitated. However, the percentage of family participants that reported they were involved in therapy was 13 percentage points lower than that of the therapists (86% compared to 99%). This difference in the percentages may indicate that some families were being
involved in therapy by the therapists’ definitions, but may have been under the impression that the contact was not a therapy session. For example, the therapist and the adolescent might have called the family with the intention of doing a therapy session, but the family may not have understood it that way.

Another significant difference between therapists’ and family participants’ responses was the reported level of family involvement in therapy. Each participant was asked to indicate how often family members were involved. In 26 cases where there was a difference in responses between therapist and family participants, the difference between them on the scale was an average of 2 (e.g., therapist endorsed 3 on the scale, family member endorsed 5). On one hand, such a difference in responses could indicate that the therapists and families did not have the same perception of how often the family was involved in therapy. On the other hand, interpretation of the options on the scale may differ. For example, a family’s involvement in therapy “most of the time” could likely be interpreted differently by two participants. Thus, this difference in opinion is better than a difference in whether the family was involved in therapy, but such a difference does not indicate necessarily whether therapists and families agree.

Another potential explanation for the difference in responses regarding frequency of family involvement in therapy is the respective knowledge of the two groups about the adolescents’ therapy. The therapist conducts both individual and family therapy sessions, so he/she is informed about the ratio of individual to family sessions. Family participants would not necessarily be as informed about how many individual sessions are conducted compared to family sessions, simply because they are not present for individual sessions.
Thus, families could be under the assumption, for example, that 25% of all therapy sessions for the adolescent are individual and 75% are family therapy sessions, while the therapist knows that the ratio of individual sessions to family sessions is 50:50.

**Research Question #3: What Recommendations Do Therapists and Family Members Have for Family Involvement in Residential Treatment and Therapy?**

Analysis of the data related to this research question may be the most valuable information that the participants offered. Therapists and families gave their opinions about something they experienced firsthand. The questionnaire item about which all participants agreed the most was the frequency of phone calls from the families. This recommendation is reasonable in that most of the participants reported that phone calls were a consistent part of family involvement in treatment in general. It also seems that compared to each of the other forms of family involvement listed on the questionnaire, phone calls would be the easiest type of involvement to facilitate.

It was interesting to find that among the five items about recommendations for family involvement, the least popular was home visits by the adolescent in treatment. The other items indicate interaction, but not in the family’s home. Rather, families interacted over the phone, in the treatment center, or in a location outside the center. A logical explanation for this type of response from the participants might be the location of the RTC. If the RTC is far from the family’s home, home visits by the adolescent may be too difficult or expensive to facilitate. Another explanation is the family’s concerns
regarding safety. One family member indicated that he/she felt that in many cases, having the adolescent in the home during the treatment process would actually be dangerous to the family. This parallels what the literature says about families’ feeling uncomfortable or even unsafe in their own homes as a result of the problems with their adolescents (de Boer et al., 2007). It thus appears that these families who share such concerns about having the adolescent make home visits want to be involved but would much rather be involved in the treatment process in other ways.

Responses to the item about recommendations for frequency of family participation in therapy were quite diverse. There could be many reasons for this. Recommendations for frequency of family therapy sessions may have matched what therapists and family members were experiencing firsthand. Those who endorsed more frequent family sessions may have had good experiences with family therapy and those who endorsed less frequent sessions had bad experiences or found it difficult to attend sessions. Having a range of responses could mean that this area of family involvement in therapy has not been researched and explored as much as it needs to be.

Limitations of the Study

There are several limitations in this study. First, the number of participating RTCs was low and the diversity of programs was lacking. Despite my efforts to include many different types of RTCs, some programs declined to participate. Also, this study used participants from only six different facilities that were selected through convenience and three of these facilities housed all adolescent sex offenders. Thus, results cannot be
generalized to other treatment centers or family involvement in adolescent residential treatment in general. Participation from therapists and family members from more residential centers would offer a better representation of diversity of presenting problems, of the ways that centers involve families in treatment, and of the ways that therapists and families view this involvement. It would also be beneficial to have a representation of more than three counties within the state and from more than one state.

Another limitation of the study is a potential bias factor with the therapists and the families. Participants may look more favorable if they report more family involvement. For the therapists, endorsement of greater family involvement in a family therapy study may give the impression that such treatment is favored when it may not be. For the families, endorsement of greater family involvement may give the impression that the family is maximizing the treatment that their adolescent is receiving. Thus, there may have been embellishment or a display of social desirability in the responses of the participants as they filled out the questionnaires.

A significant limitation of the study was a lack of clarity in some of the items on the questionnaires. For example, the item that asked whether any family member was involved in therapy seemed to be confusing to some participants. Several participants marked, “no” on the questionnaire and then answered other items in a way that contradicted the earlier item, suggesting that they did not understand what “no” for that item meant. Thus, data from this item may not be reliable. Another item that seemed to be confusing to participants was about how many months the adolescent had been in therapy. It appeared that some family participants were answering the item in terms of
how long the adolescent had been in therapy overall as opposed to how long the adolescent had been in treatment at that particular RTC.

Another limitation regarding the format of the questionnaire was the difference in the wording of options between the item about ways the family was involved in therapy and the item about recommendations for family involvement. In the former, letters and e-mails were separate options that participants could endorse. In the latter, letters and e-mails were included together in the same item (i.e., letters/e-mails); they should have been separate in both instances. Also, I asked therapist participants about the number and duration of scheduled family therapy sessions per month, but did not ask families the same question.

The instruments used for this study were adequate to provide data for the research questions. However, the depth of the research questions did not lend themselves to capturing a complex picture of what was going on with family involvement.

**Implications**

**Practice**

Information from the participants of this study indicates that many families are limited in how involved they can be in treatment of their adolescents in residential centers based on circumstances such as distance from the treatment center and income. This is an important consideration for several reasons. First, there is diversity of circumstances among adolescents and families working with RTCs, a factor that for most programs will not change and that affects families’ involvement in treatment. In this study, given the
apparent interest of the families, it would make sense for families and therapists to be working together to develop an initial plan of family involvement that accounts for and is realistic given the family’s circumstances (Demmitt & Joanning, 1998). These plans can and should be adjusted as those circumstances change.

Although the literature on this research topic suggests that increased family involvement leads to better outcomes in residential treatment (Lakin et al., 2004; Landsman et al., 2001; Nickerson et al., 2004, 2006), it is not clear what types of family involvement are most important. Family involvement in and of itself is likely not the difference between good and bad outcomes. Rather, family involvement that is planned, measured, and suited for the progress of the adolescent would likely bring about better outcomes. For example, plans for family involvement might be more effective if therapists and families were able to identify together which types of family involvement should be made a priority over others and how to maximize results when ideal involvement is not possible. This would seem to be especially useful for families who do not have access to an abundance of resources and can involve themselves in a limited number of ways in their adolescents’ treatment (e.g., using what money they have to make sure they are involved in phone therapy as opposed to using it for family visits to the treatment center). Clearly these hypotheses would have to be tested further.

**Future Research**

An important implication that emerged from the findings of this study is that involvement in treatment can follow different forms. In this study, there was only a differentiation made between family participation in treatment generally and family
participation in therapy. As analyses were conducted on data of the families’
involvement in treatment, it became clear that there should have been a distinction made
between casual involvement in treatment (e.g., a phone call from the family to the
adolescent to chat) and involvement in treatment that is recommended based on the
adolescent’s treatment objectives. One category would be family involvement in therapy.
This would involve some participation of the family that would allow them to participate
in therapy with their adolescent. A second category would be involvement that relates to
the treatment objectives for adolescents. A third category would be maintaining
connection between the adolescent and the family that does not necessarily relate to
treatment.

It is also possible that different forms of family involvement lie in a continuum
and are not categorical. One end of the continuum might be contact between the family
and the adolescent that is not treatment-oriented. The other end of the continuum might
be contact between the family and the adolescent that is in the form of residential
treatment therapy. Between the two are many ways that families have contact with the
adolescent that may or may not be treatment-oriented. Future research about these
different areas of family involvement would be useful, such as how much each category
should be used based on a variety of variable such as the presenting problem, the
developmental level of the adolescent, the progress that the adolescent is making in
treatment, and so forth.

It was noted in the literature review that parents have reported that RTC staff did
not ask them what treatment goals would be appropriate for their adolescent (Demmitt &
Parents’ involvement in the development of treatment goals is one example of a type of family involvement that would fall on the continuum of the types of family involvement. Perhaps this is an area that future research could address.

As was learned from some of the participants, a negative aspect of family involvement is when families involve themselves too much in treatment and therapy. Further research is needed about what kind of involvement and how much is appropriate for each adolescent and their specific situation, as well as what can be expected from cases where families are insufficiently or overly involved. It would also be beneficial to know whether certain presenting problems lend themselves to a need for more family involvement compared to other presenting problems.

Although it is valuable to know the ways in which families are involved in residential treatment, the data received from the participants of this study do not account for the frequency, intensity, and duration of these types of involvement. Thus, it is not known what kind of weight or importance each type of family involvement carried. Future research that addresses this would provide more information regarding the emphasis and importance that is placed on these different types of family involvement. It would also be beneficial to know more about which types and what frequency, intensity, and duration of family involvement lends itself to more positive outcomes.

**Replication of This Study**

A replication of this study would likely produce better results if the format of some questions was changed. For example, as I collected the data and began analyzing, I realized that I left an important item out of the questionnaire: “What single type of family
involvement do you consider to be best?” I also would have asked participants how often adolescents were seen in individual therapy sessions, how often and how long the family was seen with the adolescent, and how often and how long family members were seen without the adolescent. Another set of questions that I would have asked was how satisfied the families were with the type and level of involvement they had experienced and how satisfied they were with treatment. Also, instead of asking participants which family member was most involved in therapy, perhaps it would have been more useful to use a Likert-scale question to ask family members how involved each was in therapy.

It was noted earlier in this chapter that there may have been confusion among participants regarding the definition of family involvement in therapy. Responses from the therapists and the families may have been more reliable if the surveys had included a definition of family involvement in therapy so that the participants would not be left to interpret the meaning of the term on their own.

**Conclusion**

This study of 24 therapists and 64 family members representing 109 adolescent residents of six residential treatment centers aimed to better understand therapists’ and family members’ points of view about family involvement in residential treatment for troubled adolescents. The study also investigated the therapists’ and family members’ recommendations for family involvement in residential treatment. Findings suggest that (a) the families from this study were involved in many different ways in their adolescents’ treatment, (b) there were areas in which therapists and family members were similar and
areas in which they differed about how involved the families were in treatment and therapy, and (c) the therapists and family members recommend that families should be involved in therapy but recommend some forms of involvement over others.
REFERENCES


Tanielian, T., Jaycox, L. H., Paddock, S. M., Chandra, A., Meredith, L. S., & Burnam, M. A. (2009). Improving treatment seeking among adolescents with depression:


APPENDICES
Appendix A
Administrator Contact Script
Text of E-mails for Therapist Online Surveys
Text of E-mails for Family Online Surveys
Therapist Form
Administrator Contact Script

Hello. I appreciate your spending some time to talk with me about my study. I am doing a research study that will hopefully shed some light on opinions about family involvement in residential treatment. This study is also designed in a way that will likely be helpful to you and to the therapists in your residential treatment center/agency.

I am contacting you because I would like to recruit the help of therapists from your agency and the families with whom they are working. Basically, the therapists and families will be asked to fill out a survey about their opinions regarding the level to which families are and should be involved in residential treatment. The therapists will fill out the surveys first – I would like them to fill out one survey for each of the adolescents they are working with. The survey should take about 10-15 minutes to complete. Then they will pass on a survey packet to the families of the adolescents. While this may be a fair amount of time for therapists to give to this study, I believe that it will be very helpful for the therapists in evaluating the ways and the extent to which each family is involved in the residential treatment process of their adolescent. I will not be able to share information from individual families, therapists, or agencies, but will be more than happy to share the overall results of the study with you and the therapists.

The family participants will only fill out one survey that also should take about 10-15 minutes to complete. This study is completely anonymous. No participants will be asked to include information on the surveys that will allow me to identify them. Is this a study that you and your agency would be willing to participate in? What questions do you have about the study? How many therapists are currently working with adolescents at your treatment center? How many families are represented in your treatment center? Is there a time in the near future that I could meet with you and the therapists at a staff meeting?
Text of E-mails for Therapist Online Surveys

Dear _________ (therapist name):

Below is the link to Therapist Survey #1. Please only fill out this survey once.

Use the following code for question #1: _______ (individual’s code)

Survey #1: ________________________________ (link)

The next part is Therapist Survey #2. Please fill this survey out as many times as you have adolescents with whom you are working. The first time you fill out the survey you will answer the questions based on your experience with adolescent #1, the second based on adolescent #2, and so on. Use the following codes for these surveys:

Adolescent #1: _______
Adolescent #2: _______
Adolescent #3: _______

Survey #2: _______________________________ (link)

Thanks again for your help. E-mails for the family surveys will follow.

--Jonathan Zabriskie
Text of E-mails for Family Online Surveys

Dear ____________ (therapist’s name):

Here's the e-mail I promised. Please forward this on to the family of adolescent #___. The e-mail attachments are the letters for the family. They should read the letters first. Then they can follow this link for the survey: _________________________ (link)

We would like all family members older than 17 who have participated in therapy to fill out the survey. Question #1 on the survey asks for a code. More than one person can get on to fill out the survey (for example, a mother and a father), but they need to use separate codes for question #1. I’ve designed it so that one person can fill out and submit the survey and then it will go to the beginning of the survey for the next person to fill it out. They are also welcome to fill out the survey separately (just click on the link).

Code for 1st person: __________

Code for 2nd person: __________

Code for 3rd person: __________

Thanks again.

--Jonathan Zabriskie
Therapist Form

LEVEL #1

<table>
<thead>
<tr>
<th>Your assigned therapist #</th>
<th># of adolescents for whom you are the primary therapist</th>
<th>Would you like to fill out surveys HARD COPY or ONLINE?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Before you fill out the next section, think of the adolescents you work with in therapy in alphabetical order based on their last name (e.g., adolescent #1 below will be the adolescent whose last name would appear first in an alphabetical list of all the adolescents you work with).

LEVEL #2

<table>
<thead>
<tr>
<th># of adults in adolescent’s family who have participated in family therapy</th>
<th>Hard copy? (You must be meeting with a family member face-to-face to pass on hard copies)</th>
<th>Online survey? (This will require e-mail correspondence between you and the family)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent #1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent #2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent #3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent #4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent #5</td>
<td></td>
<td></td>
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<tr>
<td>Adolescent #6</td>
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<td>Adolescent #7</td>
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<tr>
<td>Adolescent #8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent #9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent #10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please write down your e-mail address if you or family members will submit online surveys: ___________________________
Appendix B

Cover Letter for Therapist Participants
Letter of Information for Therapist Participants
Cover Letter for Family Participants
Letter of Information for Family Participants
Dear therapists,

Hello. Dr. Thorana Nelson and Jonathan Zabriskie of Utah State University are conducting a research study regarding family involvement in adolescent residential treatment. This research study will be conducted in two stages. In the first stage, residential treatment therapists like you will fill out two surveys. The first survey includes questions about what you feel is a good level of family involvement and should take about 5 minutes to complete. The second set of surveys includes questions about the level of involvement of the families with whom you are working. Your participation is voluntary and your administrators will not know whether you participate or not.

The second stage of the study involves the participation of family members of the adolescents in residential treatment. They will be asked to fill out a survey similar to the ones you will fill out. To protect the confidentiality of the families of the adolescents in treatment, I am asking you to provide the clients’ families with the enclosed packet. In this packet is a copy of a cover letter similar to this one and copies of the survey. It is very important that you inform every family over 17 years of age with whom you are working about this study and give them the opportunity to participate, even if you think they will not participate. However, I recognize that there may be unique situations where you think asking the family to participate might compromise your therapy with the adolescent or with them or may endanger someone. You will not know which families agree to participate unless they tell you. Please help us recruit as many family members as possible. We are asking you to fill out information forms for each of your clients so that we can match responses of therapists with clients’ families, anonymously. Each of these surveys is coded so that therapists’ surveys can be directly matched with the families’ surveys.

We value your thoughts and opinions and hope that you will participate. If you are willing to participate in this study please contact us. We will go over the instructions and any remaining questions you may have. If you would prefer to fill out an online survey on a secure website, please let us know when you contact us. We will then provide you with access to the survey online. To preserve confidentiality should you decide to fill out the survey online, any e-mails will be destroyed once correspondence is complete. Any means of contact information provided will be destroyed once you have received the e-mail for the online survey. Please reach out to Jonathan Zabriskie by phone (801-471-7080) or by e-mail (jdzabriskie@gmail.com). We appreciate your consideration of this study and hope that you will contact us to volunteer your participation.
LETTER OF INFORMATION

Therapists’ and Families’ Views of Family Involvement in Adolescent Residential Treatment

Therapists

Introduction/ Purpose  Dr. Thorana Nelson and Jonathan Zabriskie in the Department of Family, Consumer, and Human Development at Utah State University are conducting a research study to find out more about family involvement in adolescent residential treatment. You have been asked to take part because you are a therapist at a residential treatment program. There will be approximately 80 total participants in this research study.

Procedures  If you agree to be in this research study, you will fill out surveys that will take approximately 10 minutes each to complete. You will fill out the first survey once. This survey includes questions about your recommendations and opinions regarding family involvement in residential treatment. You will fill out the second survey for each adolescent with whom you are working at the residential treatment center. This survey includes questions about the ways in which the adolescents’ families are involved in the residential treatment process. You will also pass on to the adolescents’ families packets that will allow them to participate in the study as well.

Risks  Participation in this research study may involve some added risks or discomforts. These include potential discomfort in reporting the level of involvement of an adolescent’s family. There is a small risk of loss of confidentiality but we will take steps to reduce this risk, including making the survey anonymous.

Benefits  Your participation in this study will be very beneficial. One direct benefit is that filling out the survey may help you evaluate how the families of the adolescents with whom you have been working are involved in the treatment and therapy process. In terms of indirect benefits, once results are gathered, we will learn more about the ways in which treatment centers involve the families of the adolescents in treatment and what those families think about their involvement.

Explanation & offer to answer questions  Jonathan Zabriskie has explained this research study to you and answered your questions. If you have other questions or research-related problems, you may reach Dr. Thorana Nelson at (435) 797-7431 or thorana.nelson@usu.edu.
Payment/Compensation Participation in this study will allow you to be included in a drawing for one of two $50 Walmart gift cards. You will only be included in the drawing by submitting a postage-paid postcard with your name on it (this will be submitted separate from the survey, thus it will not be matched with the surveys you submit).

Voluntary nature of participation and right to withdraw without consequence Participation in research is entirely voluntary. You may refuse to participate or withdraw at any time without consequence or loss of benefits. Refusing to participate does not exclude you from the drawing, as long as you submit the postcard.

Confidentiality Research records will be kept confidential, consistent with federal and state regulations. Only the investigator and Jonathan Zabriskie will have access to the data which will be kept in a locked file cabinet or on a password protected computer in a locked room. To protect your privacy, a code or study identifier will be used on the survey instead of your name. Drawing postcards will not be kept. All other data will be stored for seven years and at that time will be destroyed. Administrators will not be informed of data from their center.

IRB Approval Statement The Institutional Review Board for the protection of human participants at Utah State University has approved this research study. If you have any questions or concerns about your rights or a research-related injury and would like to contact someone other than the research team, you may contact the IRB Administrator at (435) 797-0567 or e-mail irb@usu.edu to obtain information or to offer input.

Investigator Statement “I certify that the research study has been explained to the individual, by me or my research staff, and that the individual understands the nature and purpose, the possible risks and benefits associated with taking part in this research study. Any questions that have been raised have been answered.”

Signature of Researcher(s)

_______________________________  ______________________________
Thorana S. Nelson, PhD    Jonathan Zabriskie
Principal Investigator    Student Researcher
435-797-7431      801-471-7080
thorana.nelson@usu.edu    jdzabriskie@gmail.com
Dear families,

Hello. Dr. Thorana Nelson and Jonathan Zabriskie of Utah State University are conducting a research study regarding family involvement in adolescent residential treatment. This research study will be conducted in two stages. The first stage of this study involves residential treatment therapists. You are likely reading this because your adolescent’s therapist gave this letter to you.

The second stage of the study involves the participation of family members of the adolescents in residential treatment. In an effort to protect confidentiality, I am asking therapists to give you this letter. Please give one copy of the survey to each individual in the family over 17 years old who has attended therapy for the adolescent in residential treatment (the adolescent in treatment should not fill out a survey).

Filling out the survey will help you in evaluating the extent of your involvement in the treatment and therapy process of your adolescent. Once results are gathered, we will be able to determine how specific residential treatment centers in Utah compare to one another regarding the ways in which they involve the families of the adolescents in treatment.

We hope that you will fill out a survey. We value your opinion. If you are willing to participate in this study please fill out the survey enclosed in the packet provided you by the therapist and return all completed surveys using the postage-paid envelope contained in the packet. If you would prefer to fill out an online survey on a secure website, please contact us directly. Please call Jonathan Zabriskie at 801-471-7080. If you prefer to contact Jonathan by e-mail, please contact him using the following e-mail address: jdzabriskie@gmail.com. We will then provide you with access to the survey online. To preserve confidentiality should you decide to fill out the survey online, any e-mails will be destroyed once correspondence is complete. We appreciate your consideration of this study and hope that you will help us by filling out this survey.
LETTER OF INFORMATION

Therapists’ and Families’ Views of Family Involvement in Adolescent Residential Treatment Families

Introduction/ Purpose  Dr. Thorana Nelson and Jonathan Zabriskie in the Department of Family, Consumer, and Human Development at Utah State University are conducting a research study to find out more about family involvement in adolescent residential treatment. You have been asked to take part because you have a family member currently in residential treatment. There will be approximately 80 total participants in this research study.

Procedures  If you agree to be in this research study, you will fill out one survey that will take approximately 10 minutes to complete. This survey includes questions about your recommendations and opinions regarding family involvement in residential treatment about the ways in which you are involved in the residential treatment process.

Risks  Participation in this research study may involve some added risks or discomforts. These include potential discomfort in reporting your level of involvement in residential treatment. There is a small risk of loss of confidentiality but we will take steps to reduce this risk, including making the survey anonymous.

Benefits  Your participation in this study will be very beneficial. One direct benefit is that filling out the survey may help you evaluate your involvement the treatment and therapy process and what changes you would like to make, if any. In terms of indirect benefits, once results are gathered, we will learn more about the ways in which treatment centers involve the families of the adolescents in treatment and what families like you think about their involvement.

Explanation & offer to answer questions  If you have questions or research-related problems, you may reach Jonathan Zabriskie at (801) 471-7080 or jdzabriskie@gmail.com or Dr. Thorana Nelson at (435) 797-7431 or thorana.nelson@usu.edu.

Payment/Compensation  Participation in this study will allow you to be included in a drawing for one of two $50 Walmart gift cards. You will only be included in the drawing by submitting a postage-paid postcard with your name on it (this will be submitted separately from the survey, thus it will not be matched with the information you submit).
**Voluntary nature of participation and right to withdraw without consequence** Participation in research is entirely voluntary. You may refuse to participate or withdraw at any time without consequence or loss of benefits. Refusing to participate does not exclude you from the drawing, as long as you submit the postcard.

**Confidentiality** Research records will be kept confidential, consistent with federal and state regulations. Only the principal investigator and Jonathan Zabriskie will have access to the data which will be kept in a locked file cabinet or on a password protected computer in a locked room. To protect your privacy, a code or study identifier will be used on the survey instead of your name. Drawing postcards will not be kept. All other data will be stored for seven years and at that time will be destroyed. Residential treatment therapists and administrators will not be informed of specific data from your survey.

**IRB Approval Statement** The Institutional Review Board for the protection of human participants at Utah State University has approved this research study. If you have any questions or concerns about your rights or a research-related injury and would like to contact someone other than the research team, you may contact the IRB Administrator at (435) 797-0567 or e-mail irb@usu.edu to obtain information or to offer input.

**Investigator Statement** “I certify that the research study has been explained to the individual, by me or my research staff, and that the individual understands the nature and purpose, the possible risks and benefits associated with taking part in this research study. Any questions that have been raised have been answered.”

**Signature of Researcher(s)**

---

Thorana S. Nelson, PhD
Principal Investigator
435-797-7431
thorana.nelson@usu.edu

Jonathan Zabriskie
Student Researcher
801-471-7080
jdzabriskie@gmail.com
Appendix C
Survey #1 for Therapist Participants
Survey #2 for Therapist Participants
Survey for Family Participants
Survey #1
Therapist Participants

*To be filled out by therapists working with adolescents in residential treatment*

Please mark the appropriate category for the following:

Sex:  M ____    F ____
Age: _____
Your race (please circle one):

  Caucasian/White    African American    Hispanic/Latino    Asian
  American Indian/Alaska Native    Other (please specify) _______________

1) Ideally, how often should adolescents in residential treatment receive letters/e-mails from home (please circle the most appropriate corresponding number; for example, circle 1 for “never”)?

   1  2  3  4  5

Never    Once every 2-3 mos.    Once a month    Twice a month    Once or more a week

2) Ideally, how often should adolescents in residential treatment receive phone calls from home?

   1  2  3  4  5

Never    Once every 2-3 mos.    Once a month    Twice a month    Once or more a week

3) Ideally, how often should families make visits to their adolescent(s) in residential treatment?

   1  2  3  4  5

Never    Once every 2-3 mos.    Once a month    Twice a month    Once or more a week
4) If they’ve earned the privilege, how often should adolescents in residential treatment be allowed to go home for visits?

1 2 3 4 5
Never Once every 2-3 mos. Once a month Twice a month Once or more a week

5) How often should family members be involved in therapy with the adolescent?

1 2 3 4 5
Never Once every 2-3 mos. Once a month Twice a month Once or more a week

If desired, please elaborate on or clarify any responses from above (include question number):

________________________________________________________________________
________________________________________________________________________

Comments:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Survey #2
Therapist Participants

*To be filled out by therapists working with adolescents in residential treatment*

Please mark the appropriate category for the following:

Sex:  M ____  F ____

Age: _____

Your race (please circle one):

- Caucasian/White
- African American
- Hispanic/Latino
- Asian
- American Indian/Alaska Native
- Other (please specify) _______________

Sex of adolescent in therapy:  M ____  F ____

Age of adolescent in therapy: _____

Presenting problem of adolescent in therapy:

_________________________________________

Number of *months* adolescent has been in therapy (please circle one):

- <1
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11+

Approximate number of times you meet with the adolescent in scheduled therapy sessions per month (please circle one):

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12+

Approximate number of times you meet with the adolescent and the family in scheduled family therapy sessions per month (please circle one):

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12+

Approximately how long do individual sessions with this adolescent last (circle one)?

- <20 min.
- 20 min.
- 30
- 40
- 50
- 60
- 70
- 80
- 90
- 100+
Approximately how long do family therapy sessions last (please circle one)?

N/A  <20 min.  20  30  40  50  60  70  80  90  100+

Is the adolescent’s family living in the state (if no, please write down the state in which the family lives)?  Yes  No  State____________________

Please answer the following questions to the best of your knowledge:

1) In what ways is the family of the adolescent in residential treatment involved in his/her treatment (circle all that apply)?

   Letters  E-mails  Phone calls  Visits to the center

   Participation in therapy  Visits home by adolescent

   Visits outside the center

2) Is any member of the adolescent’s family – immediate or extended – involved in therapy with the adolescent (‘involved in therapy” means having participated in any therapy session with the adolescent and his/her therapist)?  Yes  No

   *If “no,” jump to question number 6. If “yes,” continue to question #3.

3) How has therapy involving family members been conducted (please circle all that apply & indicate how many times this type of therapy has been conducted)?

   In person _____  Telephone conference call _____  Internet video _____

   Other (please describe) __________________ _____

4) Who in the family is involved in therapy with the adolescent and what is their relationship to the adolescent (please circle all that apply)?

   Mother  Father  Adoptive/Step-Mother  Foster Mother

   Adoptive/Step-Father  Foster Father  1 Brother  2+ Brothers

   1 Sister  2+ Sisters  Grandmother(s)  Grandfather(s)  Aunt(s)

   Uncle(s)  Cousin(s)  Friend(s)  Other (please specify)____________
5) Who is involved the most in the adolescent’s therapy (please circle one)?

Mother   Father   Adoptive/Step-Mother   Foster Mother
Adoptive/Step-Father   Foster Father   Brother   Sister
Grandmother   Grandfather   Aunt   Uncle   Cousin
Friend   Other (please specify) ______________

6) How often is any family member involved in therapy with the adolescent (please circle the most appropriate corresponding number; for example, circle 1 for “never”)?

1   2   3   4   5
Never   Once every 2-3 mos.   Once a month   Twice a month   Once or more a week

If desired, please elaborate on or clarify any responses from above (include question number):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Comments: ______________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Survey
Family Participants

*To be filled out by any family member over 17 who has participated in therapy with the adolescent in treatment*

Please mark the appropriate category for the following:

Sex:  M ____    F ____
Age: _____

Your relation to the adolescent in treatment (please circle one):

Mother    Father    Adoptive/Foster/Step-Mother
Adoptive/Foster/Step-Father    Sister    Brother    Grandparent
Aunt/Uncle    Cousin    Other (please specify) ___________

Your race (please circle one):

Caucasian/White    African American    Hispanic/Latino    Asian
American Indian/Alaska Native    Other (please specify) _______________

Sex of adolescent in therapy:  M ____    F ____
Age of adolescent in therapy: _____

Presenting problem of adolescent in therapy:
_________________________________________

Number of months adolescent has been in therapy (please circle one):
<1    1    2    3    4    5    6    7    8    9    10    11+    

Number of individuals living in the household of the adolescent’s family (please circle one):
1    2    3    4    5    6    7    8    9    10    11    12+    

Is the adolescent’s family living in the state (if no, please write down the state in which the family lives)?  Yes    No    State________________________
*Total income of the adolescent’s family (please check one):

___$0 – $29,999  ___$30,000 – $49,999  ___$50,000 – $74,999

___$75,000 – $99,999  ___$100,000+

*Skip this item if you are not financially responsible for the adolescent’s family

Please answer the following questions to the best of your knowledge:

1) In what ways is the family of the adolescent in residential treatment involved in his/her treatment (circle all that apply)?

   Letters  E-mails  Phone calls  Visits to the center

   Participation in therapy  Visits home by adolescent

   Visits outside the center

2) Is any member of the adolescent’s family – immediate or extended – involved in therapy with the adolescent (“involved in therapy” means having participated in any therapy session with the adolescent and his/her therapist)?  Yes  No

   *If “no,” jump to question number 6. If “yes,” continue to question #3.

3) How has therapy involving family members been conducted (please circle all that apply & indicate approximately how many times this type of therapy has been conducted)?

   In person  _____  Telephone conference call  _____  Internet video  _____

   Other (please describe)  ______________  _____

4) Who in the family is involved in therapy with the adolescent and what is their relationship to the adolescent (please circle all that apply)?

   Mother  Father  Adoptive/Step-Mother  Foster Mother

   Adoptive/Step-Father  Foster Father  1 Brother  2+ Brothers

   1 Sister  2+ Sisters  Grandmother(s)  Grandfather(s)  Aunt(s)

   Uncle(s)  Cousin(s)  Friend(s)  Other (please specify)  ______________
5) Who is involved the most in the adolescent’s therapy (please circle one)?

- Mother
- Father
- Adoptive/Step-Mother
- Foster Mother
- Adoptive/Step-Father
- Foster Father
- Brother
- Sister
- Grandmother
- Grandfather
- Aunt
- Uncle
- Cousin
- Friend
- Other (please specify) ______________

6) How often is any family member involved in therapy with the adolescent (please circle the most appropriate corresponding number; for example, circle 1 for “never”)?

- 1
- 2
- 3
- 4
- 5

Never  Some of the time  Half the time  Most of the time  Always

7) Ideally, how often should adolescents in residential treatment receive letters/e-mails from home?

- 1
- 2
- 3
- 4
- 5

Never  Once every 2-3 mos.  Once a month  Twice a month  Once or more a week

8) Ideally, how often should adolescents in residential treatment receive phone calls from home?

- 1
- 2
- 3
- 4
- 5

Never  Once every 2-3 mos.  Once a month  Twice a month  Once or more a week

9) Ideally, how often should families make visits to their adolescent(s) in residential treatment?

- 1
- 2
- 3
- 4
- 5

Never  Once every 2-3 mos.  Once a month  Twice a month  Once or more a week
10) If they’ve earned the privilege, how often should adolescents in residential treatment be allowed to go home for visits?

1 2 3 4 5

Never Once every 2-3 mos. Once a month Twice a month Once or more a week

11) Ideally, how often should family members be involved in therapy with the adolescent?

1 2 3 4 5

Never Once every 2-3 mos. Once a month Twice a month Once or more a week

If desired, please elaborate on or clarify any responses from above (include question number):

________________________________________________________________________
________________________________________________________________________

Comments:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________