Better Relationships, Mental Wellness, and Self-Development: What Parents Expect from Residential Treatment for Their Struggling Youth

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Abstract

Parents often initiate treatment for their youth with substance use or mental health issues. For this reason, parental expectations of treatment are helpful in considering the nature of parental engagement in the treatment process and possible barriers to treatment. The goal of this study was to better understand the expectations of parents who sought residential treatment for their youth. From 638 potential parent applications, 28 individual applications were randomly selected for in-depth qualitative analysis. The most frequently expressed expectation was for youth to have better relationships with their family and with peers. Implications for treatment program design, effectiveness, and evaluation are discussed.

Keywords: treatment expectations, residential treatment, adolescents, parent involvement, mental health, substance use

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During adolescence, some experimentation with alcohol and drugs is normative. However, a minority of youth struggle with significant substance misuse that impacts their academic and relational functioning. In the United States, 8.3% of adolescents meet criteria for a substance use disorder in any given year (Kessler et al., 2012). Substance addiction during adolescence is associated with a host of negative outcomes, both individual and relational. At an individual level, youth who are addicted to substances are more likely to be involved with criminal behaviour (Harrison & Asche, 2001), more likely to be hospitalized (Griffin, Ramchand, Edelen, McCaffrey, & Morral, 2011), and less likely to be engaged with school (Renna, 2007). Youths' relationships are also strained when they have substance use problems. Their substance use often impacts the entire family, and parents are often those who are concerned about the youths' substance use and initiate inquiries for treatment (Muck et al., 2001). Given that the early effects of substance use problems can lead to life-long problems, effective intervention is critical to divert youth from this harmful pathway. The focus of the present qualitative study is to investigate parents' expectations of treatment for their adolescent who is struggling with substance use and, often co-occurring, mental health problems.

The framework for this research extends Lerner's (1991) Developmental-Contextual model to include a specific focus on close relationships, such as those with parents and peers. Previous research has indicated that youth development occurs in the context of healthy and nurturing relationships with people in their lives, particularly parents (Biglan, Flay, Embry, & Sandler, 2012; Pepler, Craig, & Haner, 2012). Central to Lerner's model is the dynamic, reciprocal, and bidirectional nature of interactions between the youth and the multiple contexts in which the youth is embedded (e.g., family, friends, school, community, culture, etc.). This framework is relevant to understanding why youth experience difficulties and how to intervene to move them back onto a healthy developmental pathway. The framework also guides clinicians and researchers to focus not only on the individual developmental variables, such as mental health symptoms, but also on youths' functioning within their networks and their development within the context of their relationships.

The program within which this research study was embedded is a residential program for youth struggling with the core developmental tasks of adolescence. Before attending the program, individuals are immersed in compromised health (e.g., hospitalizations), impaired development (e.g., school absence and delinquent behaviour), and chaotic relationships with peers and family. The program combines four services: Outdoor Behavioral Healthcare (OBH), residential treatment, parent intervention, and aftercare services. The OBH component occurs during the first two months of the program when youth live in a wilderness environment, camping in tents or yurts and engaging in physical activities such as hiking and canoeing. After the youth graduate from the OBH component, they spend the next eight to ten months at the residential campus completing high school credits, living collectively, and participating in individual, group, and family therapy. The residential treatment approach is an intensive community-milieu that provides a structured, nurturing environment

and fosters a positive peer culture. The program offers youth the opportunity to develop social skills and authentic relationships. It also encourages personal and physical development and allows youth to engage in self-exploration and growth. An important aspect of the program is that parent involvement is required. Parents meet individually with staff and attend parent groups to learn how to respond to their adolescents in developmentally appropriate ways, and both youth and parents engage in family therapy. Results from a previous study indicated that changes in youths' experience of relationships, including the quality of their relationships with parents, shifted significantly due to youths' participation in the program (Riddell, 2014). In the final phase of the program, youth are re-integrated into the community with the support of aftercare services. Given the unique nature of this program, research is necessary to document the types of expectations for change that can be anticipated from a multimodal treatment program. Further, information from this study is relevant to informing programs offering one of these services, as parent expectations are useful in considering expected program outcomes.

Since youth are embedded in family systems and those families often seek treatment for their youth (Muck et al., 2001), parental expectations of treatment are helpful when considering the nature of parental engagement in the treatment process and possible barriers to treatment (Nock & Kazdin, 2001). The goal of this study was to better understand the expectations of parents who sought residential treatment for their youth who was struggling with mental health and substance use issues.

Method

Participants and Data Selection

Ethics approval for this analysis of clinical data was obtained from the York University Ethics Review Board. All data presented are from parents who gave informed consent to have their application to the program included in the ongoing research efforts at this center.

As a part of the admission process at this youth treatment center, parents complete a comprehensive application that includes information about their adolescent's physical and mental health, behavior, academics, and relationships. Applications include several open-ended questions designed to clarify quantitative responses (e.g., if contact with police is indicated, please describe), and to offer in-depth history to clinicians (e.g., describe your child's reaction to authority figures). Among all open-ended questions on the application, the following seven were relevant to parental expectations of treatment for their youth and thus were included in the current study:

- Please tell us what you think would be helpful for us to know about the circumstances that led you to consider enrolling your child in Pine River.
- What are your specific goals for the child while receiving treatment?

- When we get to the point where you are ready to have your son/daughter back home, what will be the signs to you that this time has come? (How will you know when your son/daughter is ready to return home or leave Pine River?)
- In which particular areas do you hope Pine River is able to support the child to make changes or improvements?
- In which particular areas do you hope Pine River is able to support you and your family to make changes or improvements?
- Please describe any fears/concerns you have about enrolling the child at Pine River.
- Please provide us with any additional comments that you would like us to know about your child and your family.

From 638 potential parent applications, 28 individual applications were randomly selected for analysis. These 28 applications were from families who were later admitted to the program as well as those who inquired but were not admitted. A random number generator was used to assign random numbers to all 638 cases. All cases were assigned to five groups that included five or six cases. The number of applications used for the study was chosen as it is divisible by four, and four coders were used; and it was a manageable workload given that the data are qualitative. We chose to have five groups to allow each coder to code their own group (during the initial coding phase described below), as well as for everyone to code the same one group (during the collective coding phase below). All identifying characteristics were deleted (e.g., name, location, etc.) and each application was referred to as a case with a unique numerical identifier.

The coders were four female graduate students. Three were PhD candidates: one who studied qualitative methods and historical/theoretical issues in psychology, another studied clinical psychology, and the third studied quantitative methods (also the Director of Research and Evaluation at the program involved in this study). The fourth analyst was a master's candidate studying clinical-developmental psychology.

Analytic Approach

Since little is known about what parents expect from treatment for their troubled youth, a qualitative approach to this inquiry was appropriate (McLeod, 2001). Charmaz (2004) suggests that qualitative research should be "emergent" (p. 991). That is, researchers should learn from the data and allow it to guide their methods and research strategies. Likewise, Richards (2005) discusses the dynamic and looping process of qualitative research, and encourages modification and amendments to approaches as needed. With this in mind, it was determined that a blended approach combining thematic analysis (Braun & Clarke, 2006) with a consensual qualitative research strategy (Hill, Thompson, & Williams, 1997) would be used.

Thematic analysis is characterized as an inductive method, meaning that the themes and abstract categories derived from the data remain grounded in the language used by participants (Guest, Namey, & Mitchell, 2013; Meier, Boivin, & Meier, 2008). The goal is to develop a thematic structure that characterizes the data and stays true to the voice of respondents, which is accomplished partly through the selection of vivid quotes as exemplars of categories. A consensual qualitative research strategy is characterized by four primary guidelines: dividing the larger data set into domains (i.e., selecting passages relevant to expectations from the parent application), utilizing a team, making decisions by consensus, and using cross analysis to develop categories that are consistent across cases. These guidelines were valuable for collaborating on team decisions.

Procedure

Phase one: Initial coding and model development. Each analyst was assigned one group of five or six cases for independent exploration. Each case included responses to at least six of the seven questions from the parent application. Analysts identified units of meaning within parents' responses that seemed relevant to the domain of parent expectations. These meaning units represented a coherent and distinct thought and were typically phrases or sentences (Rennie, Phillips, & Quartaro, 1988). Analysts parsed meaning units into properties (often referred to as codes), in a process referred to as "open categorization" by Rennie (2006). Each property was labeled with a case identification number and question number. In process, as meaning units were analyzed and properties were listed, categories emerged from clusters of properties. For example, the category "academics" emerged from properties such as finish high school and complete schooling. Analysts were asked to propose and list categories when they became salient. This flexibility encouraged analysts to engage in recursive reevaluation (constant comparison) of preceding cases. For example, while moving through cases, analysts questioned whether the parent responses bore similarity to what had already been encountered in previous cases. As categories common to more than one case were observed, properties could be added or re-sorted and categories could be modified. In addition, analysts kept theoretical memos; for example, speculating about potential themes or categories that may not have been entirely clear based on the responses, but required collaborative discussion to determine their relevance.

At the completion of this phase, analysts engaged in dialogue about shared and unique properties and categories, and discussed theoretical memos. During the first meeting, properties were assigned to categories and a number of subcategories were created to represent important nuances. The first model (Model 1) was comprised of broad, one-word thematic categories and relevant subcategories. Each category and subcategory was associated with a pool of relevant properties; each property was only assigned to one category or sub-category (Braun & Clark, 2006; Hill et al., 1997).

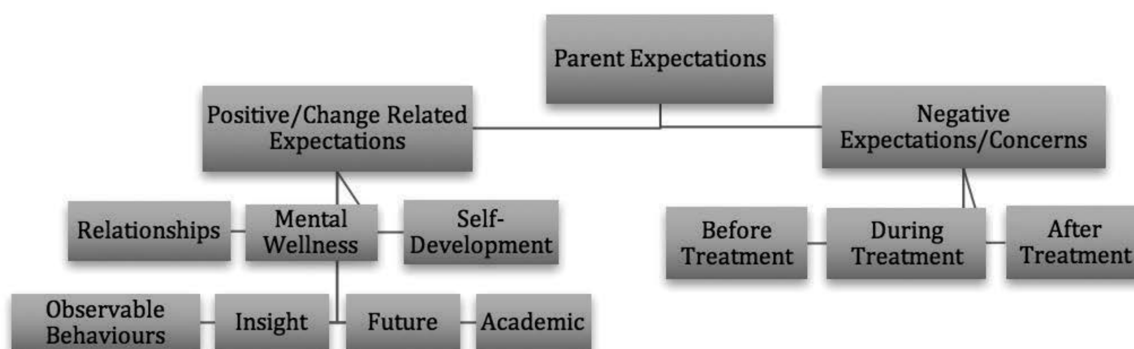
Phase two: Model confirmation. Phase two involved triangulation coding and collective coding. For triangulation coding, each analyst was assigned

another analyst's phase one cases. This was adopted to ensure that important nuances or concepts were not overlooked in phase one, and also to verify that analysts derived sufficiently similar properties and categories when interpreting the same cases. For collective coding, analysts were given the same group of five new cases to code. Cases were reviewed in consideration of the first model while utilizing the same inductive techniques described in phase one. In a second in-person meeting, the results of the collective coding, triangulation, and the model structure were discussed. During this dialogue, the model was reconstructed and analysts reached a consensus on the second stage model (Model 2).

Phase three: Revising and refinement. In this final phase, using Model 2, all analysts coded all 28 cases. During a final meeting, outstanding issues and recommendations were discussed, after which, each analyst submitted a summary of recommendations and frequency counts for all properties and categories. Using these recommendations Model 3 was developed: main and subcategories were removed, renamed, or collated; no new main categories were created and new data was coded; and, a list of revisions was circulated. The final model can be seen in Figure 1.

Figure 1

Model of Parent Expectation Main Categories



Results

Demographics & Participant Characteristics

The demographic profile of youth in the selected sample was similar to youth from the pool of applicants from which they were drawn across age (M = 17.0), gender (68% male), year of contact (range: 2007-2012), and parent marital status (57% together). Further, characteristics of youth in the sample were similar to the pool of applicants in terms of parent-reported diagnosis of learning disability (27%) and other mental health diagnoses including ADHD (45%), recent running away (19%), and contact with police (18%). The modal number of diagnoses was one. Finally, family functioning scores were below the North American norm

of 3.0 ($M = 2.34$) on the General Family Functioning subscale of the Family Assessment Device (Epstein, Baldwin, & Bishop, 1983). Differences between the study sample and the responses from the pool of all parent applications were analysed with ANOVA and Chi-Square; all p-values were greater than .05, indicating that there were no significant differences between this sample and the program population in these areas.

Content of Parent Expectations

Qualitative analyses revealed two general domains of parent expectations – positive expectations (comprising seven main categories) and negative expectations/concerns (comprising three main categories). The seven main categories of positive expectations included: relationships, mental wellness, self-development, observable behaviours, insight, future, and academics. The three main categories of negative expectations were further categorized into concerns before treatment, during treatment, and after treatment. Each category had two to six subcategories. One exemplar in each subcategory was selected to clarify its context. For all exemplars, all names were replaced with "X" and references to gender have been changed to he/she. For example, the main category of *Future* included the subcategory "setting goals" with an exemplar of "X needs to set some goals for the future and plan for how those could be achieved." Frequency counts were derived from the total number of statements made, as opposed to the number of participants who made the statement. Frequency counts were included as a way to organize categories by their prevalence; this is a useful tool for consensual qualitative research (Guest & MacQueen, 2008).

Domain 1 - Positive or Change-Oriented Expectations

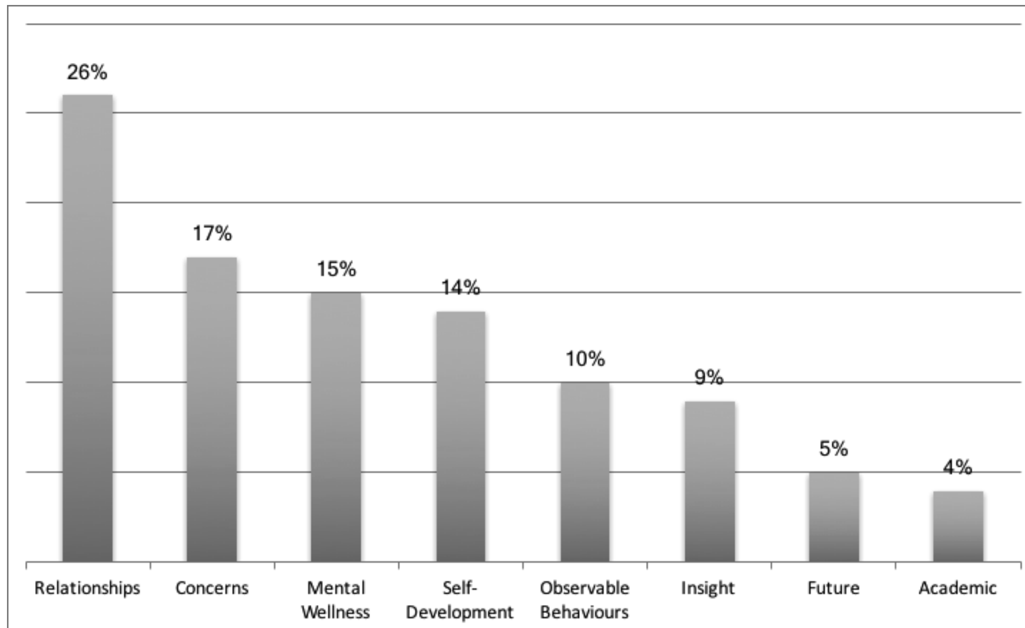
All main categories, subcategories, and an exemplar for each subcategory for Domain 1 – Positive or change-oriented expectations – can be found in Table 1. Figure 2 represents the proportion of responses belonging to each main category of positive parent expectations.

Relationships. The most prevalent theme that emerged from parent responses was relationships; in fact, 26% of all statements were relationship-oriented. Relationships included both family and peer relationships. Family relationship expectations involved four main components: a supportive family environment, respect, rebuilding and repairing relationships, and open and honest communication.

Parents articulated a desire to create a more supportive family environment for their youth. Further, parents expressed an understanding that the entire family needs to heal and work towards healthy relationships in order for their youth to make changes. In other words, many parents expressed an expectation that they would be a part of the change process. Parents expressed expectations of a supportive family environment with statements such as, "I hope they could teach us how to best react to conflict with X," and "help us give X what [he/she] needs from a home."

Figure 2

Proportion of Responses Belonging to Each Main Category of Positive Parent Expectations



Secondly, parents expressed hope that damaged family relationships could be repaired and trust re-established. Parents expressed this expectation in a number of ways, including wanting their youth to "work out a way of getting back into the family," and "'make up' some of the things that [he/she] has done."

As part of "relationships," it was important to parents that youth showed greater respect, followed family rules, and contributed to the family. As articulated by one parent,

> "X must willingly work with us to talk about expectations and responsibilities.
>
> X can't just come home and plop on the couch. It's all about attitude and a willingness to move forward. . . . But most importantly, X needs to treat us with respect and kindness."

The final aspect of family relationships was an expectation of more open and honest communication, including the youth showing a willingness to communicate and share his/her feelings. One parent expected the program to "help in establishing open communication with my [son/daughter]." Another parent viewed "helping [him/her] to express [his/her] feelings" as an important part of the process of change.

PARENT EXPECTATIONS OF YOUTH TREATMENT

Expectations about improved peer relationships comprised only 6.5% of the overall model and were defined by two aspects. The first involved the parental expectation that treatment would provide an opportunity for youth to be removed from or break ties with negative influences by being away from drug culture and deviant social circles. Secondly, parents expressed an expectation that their son or daughter might reengage in healthy peer groups during and after treatment.

Table 1.

Positive or change-orientated expectations (Domain 1)

Subcategories	Exemplars	Average Frequency
Main Category 1: Relationships		
Family		
Supportive family environment	I hope PRI can help me/our family understand how we contribute to the problems X is having. I hope we can have the opportunity to hear what changes we need to make to support the changes we hope X can make. I hope we can explore parenting practices that may be better suited for X.	17.0
Respect	We ([his/her] father/me/step father) can help [him/her] face the future but in exchange we all need respect and kindness, participation and cooperation.	16.5
Rebuilding and repairing relationship	Be able to reconnect with the family in a positive way and rebuild [his/her] relationship with [his/her] sister.	13.5
Open and honest communication	I would love to be able to talk to my [son/daughter] and work together to help [him/her].	9.5
Peers		
Re-engagement	I would love for X to become more at ease with having appropriately honest, face-to-face social interactions with peers.	4.0
Removal from negative influences	Being away from X, the “not so good” friends	2.5

Main Category 2: Mental Wellness		
Coping strategies/skills/tool	For X to get the coping tools [he/she] needs so [he/she] doesn’t continue to turn to drugs and alcohol...	14.5
Emotion regulation/self-control	We hope that [he/she] will find ways to express [his/her] feelings without resorting to anger and breaking things.	8.5
Joy/happiness	X will be welcome to come home when the “old X” returns; the [guy/gal] who finds joy in things again, pleasure in being with people, liking most people and laughing again	5.0
Healing/letting go past	Therapy - get [him/her] to the root of [his/her] issues, allow him to vent [his/her] pain and see [him/her] thru that process.	3.5
Balance/stability	We would like [him/her] to become the well balanced person we all know and love.	3.5

Main Category 3: Self-Development		
Improved self-esteem/self-worth	Help [him/her] improve [his/her] self-esteem and see [himself/herself] as a person of value.	13.5
Personal and social responsibility	We want our [son/daughter] to become the person we raised [him/her] to be, respectful, self-disciplined and socially responsible.	12.0
Identity	To help X find [himself/herself].	4.5
Autonomy	Having [him/her] gain skills and independence	4.0

Main Category 4: Observable Behaviours		
Absence of substance use	Of course I hope Pine River is able to help [him/her] end drug usage, ...	20.0
Spending time in a normative/ socially acceptable way	I will know that [he/she] will be ready to return home when [he/she] is able to act on [his/her] wishes to deal with day to day life. By this I mean that [he/she] wants to go to school and get an education and a job, get a [boyfriend/girlfriend] and play [his/ her] guitar/join a band but [his/her] problems hold [him/her] back.	4.0

Main Category 5: Insight		
Impact of drug use/externalizing behaviour on family	When [he/she] is able to recognize the extent to which drugs have adversely affected [his/her] life. Also when [he/ she] demonstrates some remorse for [his/her] reckless behaviour which I believe would be reflective of conscientiousness.	12.5
Insight in general (different forms of “realization”)	Once [he/she] has realized [he/she] doesn’t need drugs to feel good.	6.0
Understanding motivations for behaviour (e.g., insight into drug use)	An understanding of why [he/she] uses and how [he/she] has learned to cope when stressed.	2.5

Main Category 6: Future		
Setting goals/making plans	[He/She] needs to set some goals for the future and a plan for how those could be achieved	7.5
Reaching potential	We hope PRI can teach [him/her] strategies to help [him/her] cope so that [he/she] can reach [his/her] potential.	3.5
Purpose in life/desire to move forward/hope/ looking towards future	[He/She] will have an idea of what [he/she] wants for [himself/herself] and [his/her] life, a sense of purpose.	3.0
Main Category 7: Academic		
Academic attainment or progression	[He/She] is very eager to complete [his/her] high-school credits and...	6.5
Academics as a means to vocation	We hope [he/she] will realize that [he/she] is capable of doing [his/her] school work ... and that [he/she] will realize that there are ways he/she will be able to learn and eventually get a job.	4.0

Mental wellness. Parental expectations related to mental wellness were focused on the desire for the youth to have positive emotional experiences (i.e., joy/happiness) and be able to cope with negative emotional experiences (i.e., developing coping strategies, healing, emotion regulation). Parent expectations about mental wellness contributed 15% to the overall model.

The most prevalent aspect of mental wellness was parental expectations that their son or daughter would develop skills to handle life stressors and cope with mental health problems. For example, one parent expressed, “We hope X will develop new strategies for dealing with everyday situations that can cause stress at school, home, [and] work.” Similarly, parents hoped their youth would develop a greater capacity to self-regulate and control their emotional and behavioural reactions. Parents also hoped treatment would help their youth achieve greater mental wellness by supporting them in healing and letting go of previous negative experiences.

PARENT EXPECTATIONS OF YOUTH TREATMENT

Self-development. Parents' articulations about self-development included four components: improved self-esteem/self-worth, personal and social responsibility, identity, and autonomy. Expectancies that focused on self-development accounted for 14% of the model.

A prevalent expectation of parents was for their youth to improve their self-esteem or self-worth. For example, one parent hoped that treatment would result in their son/daughter "feeling good about [himself/herself], trusting in [himself/herself], believing [he/she] can work to reach [his/her] dreams and goals." Another predominant theme that characterized self-development was the expectation that the program would help the troubled youth along a path towards becoming a more responsible young adult. This included taking more personal responsibility (i.e., for their own self-care and life decisions), as well as behaving in more socially responsible ways (e.g., not breaking the law). One parent hoped that the program would help guide his or her youth "toward becoming a socially and personally responsible and conscientious individual." Related to personal responsibility was the expectation that youth would become more autonomous, or as one parent stated, "support X to become more self-reliant."

Parents also mentioned the hope that their youth would experience development in their identity or sense of self. One parent expressed a desire that their youth would be able to "get a better sense of [his/her] strengths and who [he/she] is." Parents hoped that the program would provide opportunities for identity exploration and the development of greater self-awareness.

Observable behaviour. Parents expected intervention to lead to improvements in observable behaviours, primarily the reduction of or abstinence from substance use. Parents also anticipated that after treatment, their son/daughter would spend time in more socially acceptable and normative ways. These normative and socially acceptable activities included a variety of hobbies and interests (e.g., music, sports, theatre arts), all of which conveyed the overall message that their son/daughter would resume past activities and/or take up new interests. In other words, parents wanted a clear indication that their youth was putting their energy in the right direction. As articulated by one parent, "X is smart but has not applied [himself/herself] in positive pursuits. X is entrepreneurial and could do quite well if [he/she] were to focus [his/her] efforts on legal/ healthy activities." Observable behaviours accounted for 10% of the model.

Insight. Insight involved three main components: insight into the impact of past behaviours, insight in general, and insight into motivations for past behaviours. The first expectation of increased insight included gaining perspective on the impact that their previous drug use and behaviours had on their family and expressing remorse for these behaviours. One parent stated, "I feel that X needs support with respect to understanding the impact of [his/her] drug using lifestyle (i.e. socially, physically, emotionally, legally, etc.) as well as the impact that [his/her] mental health issues are having on our family."

Secondly, the term "realization" occurred in parent responses, which was coded as insight in general, as it covered a range of topics (e.g., realize they can cope with mental health issues, realize they can succeed in school, etc.). Finally, parents hoped treatment would help the youth understand the underlying reasons for their previous behaviours and substance use. For example, one parent stated that they hoped the program would help their youth "find the reason X needs to take the drugs."

Future. Parents expected treatment to be associated with increased goal setting behaviour, greater ability for youth to reach their potential, and a greater sense of purpose in life. Goal setting included the youth making concrete goals for the future and a plan to achieve these goals. For example, one parent expected that "hope and goals for [his/her] future will be more clear and structured" after the program. Parents also expected changes in their youths' future orientation, including feeling that they have a purpose in life and a sense that they can reach their potential. Parents expressed these thoughts in statements such as "I would like [him/her] to see a future for [himself/herself]," and "help X clean [himself/herself] up, finish high school and achieve [his/her] potential." The future category accounted for 6% of the total model.

Academics. Expectations about academics were a small element in the overall model of parent expectations, contributing 4% of the responses. Specifically, some parents hoped that treatment would help their youth attain or progress in academics, such as receiving high school credits, as a goal in and of itself. Other parents saw academics as means for their youth to attain a meaningful (i.e., vocationally oriented) future.

Domain 2 - Negative Expectations or Concerns

Although the majority of parents expressed positive expectations about their youth's progress through treatment, 17% of parent statements expressed worry or concern about their youth engaging with treatment. These were grouped into three temporal periods: concerns before treatment, concerns during treatment, and concerns after treatment. All main categories, subcategories, and an exemplar for each subcategory for Domain 2 – Negative expectations or concerns can be found in Table 2. Regarding concerns before treatment, parents feared that their youth might not actually attend treatment, which included worrying that their youth would behave in a way that would prohibit their admission.

Parents also stated concerns about what might happen to their son or daughter during treatment, either as a result of the youth's behaviour or interactions with other youth. These concerns included: that he or she would not stay for the full duration of treatment, would not engage with treatment, would be lonely or miss family, or would feel abandoned. Some parents were concerned that their youth would behave in such a way as to get expelled, would run away, or would simply disengage from the program, as expressed in one parent's statement "that [he/she] won't stay the course . . . or even give it a chance." Other parents worried that their son or daughter would feel that their parents were trying to get "rid of them"

as captured by the statement of one parent, “I worry that X will view this more as me giving up on [him/her] or me trying to get rid of ‘the problem.’”

There was also a fear of contagion, that is, for their son or daughter to learn new destructive behaviours from other youth in treatment. Parents expressed concerns that their youth would “make friends with troubled teens,” effectively transporting their youth from one circle of negative peers to another. One parent worried that “[he/she] will be exposed to new negative influences. We have a great fear that [he/she] will graduate to harder drugs.”

Parents also expressed concern about the quality of treatment and the logistics of themselves being engaged with therapy. When considering treatment quality, some parents wondered if treatment staff would recognize the needs of their youth, as articulated by one parent, “I worry about whether or not [he/she] will be treated with compassion, I mean I’m sure [he/she] will but compassion with a true and insightful understanding of [his/her] life experience.” In terms of treatment logistics, some parents worried about the distance between the treatment facility and their home and the costs incurred for therapy.

When expressing expectations of treatment, concerns about what would happen after treatment arose. These included concerns about the youth not experiencing improvements and not having access to aftercare services following residential treatment.

Table 2.

Negative Expectations or Concerns (Domain 2)

Subcategories	Exemplars	Average Frequency
Main Category 1: Before Treatment		
Won't go	Concerned [he'll/she'll] just say no...	6.5
Main Category 2: During Treatment		
Won't stay	I fear [he/she] will try to leave	7.5
Quality of care and treatment logistics	The location is far from where we live so we maybe not be as involved as we would like to be.	6.0
Contagion	I am afraid that [he/she] might be around people that have much worse problems than [he/she] does and that [he/she] will learn from them.	4.0
Not present during treatment/low engagement	That [he/she] is just going to say what [he/she] thinks you want to hear and not open up about the real things that are troubling [him/her].	3.5
Abandonment/anger/ resentment	My major concern is that [he/she] will view this as my pushing [him/her] away or rejecting [him/her].	3.5
Loneliness/missing friends & family	I am worried that [he/she] will miss us and [his/her] friends and want to leave before [he/she] is ready.	2.0
Main Category 3: After Treatment		
Access to support and treatment after program	I would hope that the individuals with whom [he/she] will have established trustful relationships would check in with [him/her] from time to time and that X and the rest of us would have access to the therapeutic counsellor for guidance when needed.	5.0
No improvement	I also worry about what I will do if this does not work	2.0

Discussion

The goal of this study was to investigate parents' expectations for change in their youth during a residential treatment program for youth with mental health concerns and substance use. Data were derived from the seven questions on the program's application form that related to what parents hoped or expected might change over the course of treatment for their troubled youth, as well as concerns about enrolling their youth in the program. Results indicated a wide range of positive expectations including relationships, mental wellness, self-development, observable behaviours, insight, future, and academics, as well as concerns or negative expectations.

Relationships

The ability for youth to have healthy relationships was paramount to parents. Over a quarter (26%) of all statements related to aspects of healthy relationships, such as relationship repair, respect, communication, and creating a supportive family environment. Before entering residential treatment, youths' relationships with their families are often characterized by patterns of frequent out-of-home placements and difficult family relationships including acute and chronic conflicts (Frensch & Cameron, 2002). Despite this finding, residential treatment programs for youth do not always focus on improving family functioning or facilitating the repair of family relationships. In fact, there has been a call within the field of residential treatment to increase family involvement in treatment and develop program components to facilitate healthier family functioning (Affronti, 2009; Clarahan & Christenson, 2017; Geurts, Boddy, Noom, & Knorth, 2012; McLendon, McLendon, & Hatch, 2012; Merritts, 2016; Smith, & Issenmann, 2017). Instead of viewing the youth as the client, the program involved in this study sees the family as the client and they engage families through an annual parent retreat, parent workshops, a weekly parent support group, and monthly family therapy sessions.

Parents expected changes in their youth's peer relationships, including removal from negative influences and re-engagement with positive peer relationships. Previous research has highlighted the link between peer relationships and substance use in adolescents (Allen, Chango, Szwedo, Schad, & Marston, 2012), as well as the negative impact of deviant peer processes on youths' future problem behaviour (Dishion, Spracklen, Andrews, & Patterson, 1996). Conversely, positive peer relationships are important contexts for youths' development, particularly in terms of the opportunities they provide for youth to learn social skills and social competence (Collins & Steinberg, 2006). The program, which is the focus of the current study, creates a positive peer culture by ensuring staff model healthy relationships for youth and by facilitating process groups in which youth openly work through any issues within their peer relationships. The staff in this program are intentionally mindful of the peer culture at all times and consider how various decisions may impact the peer culture, including deciding which incoming youth are placed on each team.

Mental Wellness

Youth who seek treatment for addiction are likely to struggle with mental health problems, as the co-occurrence rate is between 64% and 88% (Brewer, Godley, & Hulvershorn, 2017). It was interesting that parents did not expect a reduction in symptoms; rather, they expressed hope that their youth would be better equipped to cope with their mental health problems and would develop positive aspects of wellness, such as balance, happiness, and emotion regulation. Emotional dysregulation has been linked to greater substance use among adolescents (Kirisci, Tarter, Mezzich, & Vanyukov, 2007), making emotion regulation an important skill for youth to develop during residential treatment. In order to support the development of emotion regulation skills, the program in the current study uses Dialectical Behaviour Therapy (DBT) as the primary therapeutic modality (Linehan, 1993). They offer a weekly DBT skills group for youth and ensure that youth have a space to work through strong emotions in the process group that occurs three times a week. Within the peer culture, value is placed on someone managing their emotions, and someone managing well is recognized and praised by other youth and staff.

Self-Development

Parents expressed an expectation that youths' sense of self would develop during the treatment process, which included developing better self-esteem and exploring their identity. Theories and research from the field of developmental psychology suggest that developing a secure and authentic sense of self is one of the core tasks of adolescence (Erikson, 1968; Plotkin, 2008) and that struggling with identity issues is linked with a number of negative outcomes for youth (Hernandez, Montgomery, & Kurtines, 2006). For example, girls with identity distress experience significantly more externalizing symptoms (e.g., anti-social behaviour), whereas boys with identity issues experience significantly more internalizing symptoms (e.g., anxiety, depression, peer problems, and social withdrawal; Hernandez et al., 2006). Thus, youth requiring mental health services may also need a supportive social environment where they are able to explore their identity. In the program discussed in this study, youth participate in individual therapy for one or two hours a week depending on the needs of the youth at that time. Youth are also placed in a group based on their stage in the program. As part of these stage groups, they receive therapeutic assignments, which include questions about who they want to be, what they admire, and the self that they present to others.

Parents expected youth to become more autonomous and take more responsibility after attending residential treatment. Establishing autonomy is a central task in adolescence, with healthy development defined by youth establishing independence from parents and other adults (Karabanovaa & Poskrebyshevaa, 2013), while still remaining connected to important people in their lives (Collins & Steinberg, 2006; Oudekerk, Allen, Hessel, & Molloy, 2015). Using longitudinal data, Allen and colleagues (1994) discovered that difficulties establishing autonomy and relatedness with parents were associated

with depression and externalizing behaviours in adolescents. In the program discussed in this study, the development of autonomy is intentionally supported during the last phase of treatment when youth prepare to transition back into their home. Staff support youth in developing an individual transition plan based on where they want to be and how they plan to practice the skills they have learned with their family and friends at home.

Observable Behaviour

Behaviours such as substance use and criminality are often the impetus for parents to seek treatment for their youth, which was reflected in parental expectations of behavioural change. For example, substance use, theft/stealing, and legal trouble were all in the top 10 reasons parents decided to send their youth to a residential treatment program in one study of 473 client files in the United States (Bettmann, Lundahl, Wright, Jasperson, & McRoberts, 2011). Previous research with residential treatment programs has focused heavily on behavioural changes such as substance use change (Godley, Godley, Funk, Dennis, & Loveland, 2001; Henderson, Dakof, Greenbaum, & Liddle, 2010), missing social events (Shane, Jasiukaitis, & Green, 2003), academics and criminality (Balsa, Homer, French, & Weisner, 2009), risky sexual behaviour (Spooner, Mattick, & Noffs, 2001), and/or recidivism (Edelen, Slaughter, McCaffrey, Becker, & Morral, 2009). In this study, however, expectations for changes in these types of behaviours only accounted for 10% of the model. Indeed, expectations of behavioural change were far less evident in the parent applications than expectations of youth's capacity to develop and maintain healthy family relationships and to achieve mental wellness. This suggests that residential treatment programs should focus on, and measure changes in, relationships, sense of self, and mental wellness, in addition to expecting and measuring changes in observable behaviour.

Insight

Parents expected that their youth would gain insight into the consequences that their substance use and behavioural problems had on the family. Parents also articulated an expectation that youth would gain insight into the motivations underlying their behaviours, including their substance use. Rogers (1944) defined insight as the perception of new meaning in the individual's own experience and saw insight as a necessary condition for positive behavioural change. Russell and Gillis (2010) discuss using experiential therapy in various therapeutic contexts (e.g., therapeutic boarding schools, wilderness therapy) to help youth examine past and current behaviours and gain insight into the motivations behind them. Curtin (2010) detailed specific practices to create a therapeutic community that may facilitate youth gaining insight into their behaviours, including holding community meetings and facilitating peer feedback. The program discussed in this study helps youth develop greater insight during individual therapy, process groups, and stage groups by asking youth about the obstacles that got in the way of their development. They also create novel opportunities for reflection on their interpersonal patterns as they unfold during the OBH and equestrian therapy

components of the program. For example, as part of the equestrian therapy program one youth exclaimed, “Wow, I really let that horse walk all over me.” Integrating these practices may be useful for other residential programs wishing to target the parental expectation of helping youth develop greater insight.

Future

Parental expectations in the future category included youth setting goals, developing a greater sense of their purpose in life, and reaching their potential. Adolescence is a crucial period for the formulation of personal goals, decisions about educational opportunities, the consolidation of social values, and the construction of future plans (Carroll, Durkin, Hattie, & Houghton, 1997). Individuals with high levels of future orientation are less likely to use drugs and alcohol as adolescents and over the course of their lives (Peters et al., 2005; Robbins & Bryan, 2004). Research on resilient youth has identified optimistic future expectations, personal goals, and a strong sense of purpose as key components of well-being (Seligman, 1990; Smokowski, Reynolds, & Bezruczko, 2000), indicating the need for residential treatment programs to help youth develop skills such as goal setting. The program discussed in this study does this mostly through the use of the stage system. In order for youth to progress to the next stage of the program, they have specific interpersonal and behavioural goals that must be reached. Youth learn that their behaviour today will impact their future and are supported in making choices that will move them towards their goals, including their goal of graduating from the program.

Academic

In the final positive expectation category, parents indicated a desire for their youth to reach their academic potential, as well as continue their education in order to pursue a vocation. Before beginning residential programs, many youth are not regularly attending, have been expelled from, or have dropped out of school. Indeed, Bettmann and colleagues (2011) found that school problems were the third most prevalent reason for parents sending their youth to a residential treatment program. Not completing their high school education places youth at-risk for future social and financial difficulties. For example, adults with less than a high school education are twice as likely to experience unemployment compared to high school graduates, three to four times more likely to experience unemployment compared to college/university graduates, and are at greater risk for social exclusion and a host of additional risk factors (Hango & De Broucker, 2007; Jackson, 2003). It is important for residential treatment programs to implement a system that enables youth to work towards academic goals such as gaining credits towards their high school diploma or post-secondary degree. The program discussed in this study does this by providing individualized educational programming and creating a community of learning in which the goal of getting a job or getting into a college and university is celebrated by peers and staff.

PARENT EXPECTATIONS OF YOUTH TREATMENT

Concerns

Many families who seek residential treatment have tried other methods of therapy such as individual counselling, outpatient, or day therapy (Bettmann et al., 2011) and are uncertain as to whether residential treatment will be more effective. Parents also expressed concerns that their youth would act in ways that would prohibit admission or ongoing treatment, or simply refuse to go. These concerns make sense given the current policy governing treatment centers in Ontario, which specify that adolescents must willingly consent to participate in treatment (e.g., Child and Family Services Act, 1990). Before attending the program, the admissions director meets with families, often to help address their concerns before starting treatment. In the first phase of treatment, the OBH therapist has phone calls with families for two hours a week to help work through any concerns they have at the beginning of treatment. Parents also have the opportunity to attend a parent support group in person or over the phone that is facilitated by a staff member.

Parents' concerns about contagion warrant consideration, as youth may indeed find deviant peers while attending programs for youth who struggle with similar problems (Dodge, Dishion, & Lansford, 2006). High-risk adolescents are particularly vulnerable to the effects of contagion and these aggregations with deviant peers may inadvertently reinforce problem behaviour (Dishion, McCord, & Poulin, 1999). As discussed above, the program discussed in this study mitigates the possibility for contagion by modeling of healthy relationships and creating a positive peer culture.

Based on the results of this study, discussing parental concerns as a part of the admissions process is recommended. Specifically, this dialogue should address how youths are retained and under what circumstances they may be discharged (e.g., fire-setting), what to expect in terms of peers at the treatment centre (e.g., the promotion of positive peer culture), and how financial and logistical concerns may be addressed (e.g., through foundation bursaries or insurance).

Limitations

The goal of this study was to study an under-explored area of inquiry related to youth mental health and substance use treatment. Making use of pre-existing data was advantageous, as it avoided the need for parents to contribute information while they were in a state of crisis and stress. This approach also has limitations, namely, the questions were not constructed to be specific to the research question of this study. Instead, they were created as part of an application process to inform admissions and treatment planning. Although the selective analysis of parent expectations from the larger admission application developed a more focal understanding of parental expectations, it reduced the amount of information on which this understanding was based (as would be accomplished in an in-depth interview). Moreover, the small sample size (28 individuals or approximately 4.5% of the study population) and the fact that all

applications were to a single treatment program were both limitations. For these reasons, this study should be considered preliminary and a first step toward future research into parental expectations of youth treatment.

Implications for Clinical Practice and Treatment Evaluation

The findings in this study suggest that the parents' expectations of treatment for their youth extend beyond the primary reason for applying (e.g., substance use) and are complex and comprehensive. Parents have clear, specific, and well-developed expectations for change across family relationships, mental wellness, self-development, insight, future-orientation, and academics. Treatment centres could consider these findings when planning programs, communicating with parents, and developing plans for program evaluation. Based on the results of this study, recommendations for treatment programming include:

- Employing formal individual and family therapy to facilitate healing and facilitate the repair of the parent-adolescent relationship
- Focusing on creating a positive peer culture to limit any potential negative influences of deviant peers and encourage growth through positive peer relationships.
- Focusing on developmental tasks such as developing a secure sense of self and establishing autonomy to help move youth onto a healthier developmental path.
- Helping youth develop skills such as career planning and goal setting, and implementing a system that enables youth to work towards academic goals such as gaining credits towards their high school diploma or post-secondary degree.
- Discussing parental concerns as a part of the admissions process, including concerns parents may have before, during, and after treatment.
- Considering parental expectations when designing evaluation tools to ensure that core parental expectations are measured as program success indicators.

The results of this study have deepened the understanding of what parents expect from residential treatment for their troubled adolescent. The next step in this line of inquiry is a validation of the findings using a quantitative confirmatory approach, preferably from multiple treatment centres that offer various treatment modalities.

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