Experiential Therapy in the Mental Health Treatment of Adolescents

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Abstract

This paper identifies non-profit and for-profit adolescent residential treatment programs in the United States and hypothesizes the number of adolescents who will enter residential treatment in a typical year. We then explore through a survey of open ended responses how programs or clinical directors define and apply "experiential therapy," including what theoretical basis and practical methods may guide their therapeutic approach in residential treatment. The results indicate that the majority of residential treatment programs believe they are practicing what is defined in this paper as experiential therapy, and that a model of the therapeutic process may be warranted. Central to the model is the use of intentional experiential activities to achieve a variety of therapeutic goals. The proposed model of the theoretical basis, process and reported outcomes provides a framework for practitioners, researchers, and other mental health professionals to continue discussion on the use of experience as a therapeutic tool. The model begins to shed light on the discussion of why experiential methods may be more approachable for adolescents and parents who are turned off by the stigma and barriers presented by traditional residential treatment models.

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Introduction

According to the U.S. Department of Health and Human Services (2008), approximately 2.9 million youth received treatment for emotional or behavioral difficulties. Of these youth, approximately 40% received treatment in their respective schools, 25% were treated by a pediatrician or general medical practitioner, and 9% were treated by a practitioner offering complimentary or alternative medicine. This leaves approximately 700,000 youth who received treatment from either an outpatient or a residential treatment model in a typical year. Though outpatient psychotherapy is the most common and likely form of treatment for these youth and is the most extensively studied intervention (Weisz, Huey, & Weersing., 1998), in many cases, this intervention fails to result for many youth, including a reduction in the psychological or emotional issues which may have led them to seek treatment and improved family functioning (Burns, Hoagswood, and Maltsby, 1998).

Instead, many of these youth continue to move through the continuum of care after the above types of interventions fail, with the end result being the need for more restrictive settings like residential treatment. Most youth considering residential treatment have tried other forms of treatment and clearly constitute a difficult population to treat effectively (Russell, 2007). Many youth and families are turning more and more to 'experiential therapy programs' that utilize alternative approaches that are largely misunderstood in terms of their therapy, process, and practice. In a recent paper, Russell, Gillis, and Lewis (2008) offered several conclusions regarding the emerging residential group-based treatment alternatives for youth who practice what some researchers are calling 'experiential therapy.' Key among these were their appeal to families, social service agencies, corrections, and other professionals looking for less stigmatized residential treatment options and the increasing need for evaluation and research to determine the scope and relative effectiveness of these types of services.

To better understand this emerging treatment approach in adolescent mental health, this study proposes: 1) to conduct a review of the relevant literature on the adolescent behavioral healthcare service industry operating in the United States and Canada and the well documented historical demand for youth services, 2) to

estimate the number of adolescent residential treatment programs and subsequent student numbers based on data to be acquired from national accreditation agencies, and 3) to conduct a preliminary survey of clinical directors belonging to a national association of residential treatment programs to explore how experiential therapy is practiced in their programs. The survey will be guided by the question: What is experiential therapy and what does it look like when practiced with adolescents in your program? Stemming from previous work by Russell (2008), it is hoped that the results of this study will shed new light on the following issues associated with adolescent mental healthcare in the United States: 1) the persistent and growing problem of a lack of healthcare services for adolescents, 2) the growing movement and subsequent discussion on the role that residential treatment plays on the continuum of available healthcare services for adolescents, 3) the role that direct and intentional experience play in the treatment of adolescents in residential settings, 4) the need to better understand how experience and activity are integrated within existing evidence based practices in residential settings.

Adolescent Residential Treatment Programs in the United States

Currently, demand outweighs the supply of appropriate and effective behavioral healthcare services for adolescents and their families. McManus (2003) examined healthcare services in four major U.S. cities, and found two significant barriers to behavioral healthcare services were provider shortages and inadequate reimbursement rates. The author states: "severe shortages of mental health and substance abuse providers trained to care for adolescents were reported in all four cities" (p. 16). In addition, few inpatient mental health beds are available for adolescents and families in need. Because of this, teens with mental health crises are often hospitalized for extended periods of time awaiting services.

The "continuum of care" talked about by behavioral healthcare experts consists of services in schools, outpatient, inpatient, day treatment, and accessible residential facilities. Such a "continuum" appears to be a myth for most adolescents and their families seeking treatment. The demonstrated historical demand and current lack of services make it highly likely that innovative programs, and more importantly, families in search of help, will utilize effective innovative programs for their children. This increased demand creates the

potential for programs without licensing, or programs that market to desperate parents and their children seeking treatment, could operate unethically without protective oversight. The potential for unethical marketing and dangerous practices (as evidenced by the GAO report (Kutz & O'Connell, 2007) highlights the importance of the need for licensing, standards of best practice, and evaluation and research on program effectiveness for these interventions.

Best Practice in Adolescent Residential Mental Health Treatment

Most research conducted on adolescent treatment services has assessed and evaluated interventions that have been described by Weisz, Weiss, and Donenburg (1992) as research therapies. These therapies are reasoned to be theorized, manual driven, resource intensive, and implemented in research settings that offer intense training, supervision, and monitoring. Many of these treatments have been shown to be efficacious, yet few of these "evidence based practices" are implemented across the country by treatment centers and other service delivery providers because of diverse client needs, staff background and experience, and because most programs subscribe to a "multimodal model" of delivery, drawing on various treatment approaches and behavioral strategies to effectuate change (Lamb, Greenlick & McCarty. 1998).

Most youth considering private residential treatment have tried other forms of treatment and clearly constitute a difficult population to treat effectively (Russell, 2007). Given the difficulty of the presenting population, and some well documented incidents of neglect and abuse, there has been increased scrutiny on residential treatment programs and subsequent therapeutic approaches used to treat adolescents. The Government Accounting Office (GAO) produced a report (GAO-08-146T) entitled Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth (2007) to "(1) verify whether allegations of abuse and death at residential treatment programs are widespread and (2) examine the facts and circumstances surrounding selected closed cases where a teenager died while enrolled in a private program" (p. 1). The GAO report led to House Bill (H.R. 911) Stop Child Abuse in Residential Programs for Teens Act of 2009, currently (February 24, 2009) referred to the US Senate Committee on Health, Education, Labor, and Pensions. This bill, not yet law, seeks to address key program characteristics

of the residential treatment industry. Some of these issues have also been detailed in several articles by a group of researchers called ASTART (Alliance for the Safe, Therapeutic, and Appropriate Use of Residential Treatment), with a particular focus on mistreatment and abuse of youth in residential care. Examples of these articles include Behar, Friedman, Pinto, Katz-Leavy, & Jones, (2007); Friedman, Pinto, Behar, Bush, Chirolla, & Epstein, et al. (2006); and Pinto, Friedman, & Epstein (2005) and make a strong case for regulations to stop abuses occurring primarily at unlicensed and unregulated facilities. They advocate adoption of policies recommended by the American Bar Association (2007) that included closing facilities who cannot provide evidence of their efficacy.

How Many Programs and How Many Served?

The number of youth in private residential treatment remains an elusive number. Cited as fact in several places (Behar, Friedman, Pinto, Katz-Leavy, & Jones, 2007; Pinto, Friedman, & Epstein, 2005) are figures from a newspaper article that estimates (without citing any evidence) 10,000 to 14,000 school age children in private residential treatment (Rubin, 2004). Friedman (2009), coordinator of A START said in a presentation during "Abuse of Youth in Residential Treatment: A Call to Action," "We were dismayed when they (GAO) were no more successful than others in coming up with estimates of the number of youth in private residential placements" (p. 3).

To estimate the number of residential treatment programs for adolescents, leading national associations and accrediting agencies were first identified and contacted. These included the National Association of Therapeutic Schools and Programs (NATSAP), the National Association the Therapeutic Wilderness Camping (NATWC), and accreditation agencies like the Joint Commission, the Council on Accreditation (COA), and the Commission on the Accreditation of Rehabilitation Facilities (CARF). From personal contacts with these bodies, a total number of non-profit and for-profit programs serving adolescents in a residential manner was solicited and identified. The programs were cross-checked across associations to the best of our abilities given the information collected. Table 1 reports the approximately 1,500 known residential treatment programs for adolescents currently operating in the United States and Canada. If each program annually served 250 students a year

(based on estimates reported by Russell, Gillis and Lewis, 2008) then approximately 375,000 adolescents a year would be treated by these programs. This means as many as 375,000 adolescents per year could be in "experiential treatment" in these types of residential programs, yet little if anything has been written on what is meant by experiential therapy.

Table 1. Related associations and accrediting agencies and corresponding total number of programs.

Associations	Number of Programs
American Marine Institute Kids	55
Eckerd Youth Alternatives	12
National Association of Therapeutic Schools and Programs	181
National Association of Therapeutic Wilderness Camps	50
Three Springs	16
Total	**314**
Accrediting Agencies	
Commission on the Accreditation of Rehabilitation Facilities	117
The Council on Accreditation	635
The Joint Commission	729
Total	**1481**

To help address the original question asked in this paper, How many adolescents in residential mental health treatment are treated using experiential methods?, we utilized a sample of programs that are theorized to represent the range of residential treatment approaches in the United States and Canada. Data from a recent survey, and contact information for programs in the National Association of Therapeutic Schools and Programs (NATSAP) were made available to help us begin to answer the question of what is meant by experiential therapy.

Experiential Therapy Defined

To help frame our discussion of experiential therapy, a review of literature was conducted. A PsycNET and Google search elicited multiple definitions when using the key word search "experiential therapy." Within the field of psychotherapy, Pos, Greenberg, and Elliott (2008) speak of experiential therapy as "knowing by experience" in the promotion of change in the client. They couch their approach within the

emotion-focused (verbal) approach to psychotherapy. The Association of Experiential Therapies (n.d) describes experiential therapy, as "a role play method through which past, present and future issues can be resolved when combined with more traditional modalities". C.M. Itin (2002) attempts to collect links to various expressions of "experiential therapy". He notes that experiential therapy is "a general expression of therapy that involves action on the part of the therapist and the client" (p. 1). He includes art, music, dance/movement, psychodrama/drama, narrative, writing, biblio, poetry, and photography as part of expressive therapies. He highlights mind/body therapies as a category of experiences used alone or as an adjunct to traditional therapy. Included among the mind/body therapies are meditation, massage, and various forms of martial arts. Under "activity therapy" he cites adjectives like recreational, play, horticultural, occupational, animal assisted (including equine), and adventure that modify and define subfields of therapy that is experiential. Itin's exhaustive description of the many fields or subfields of "experiential therapy" highlight the confusion one might encounter when using these terms without further clarification of exactly what "experience" is taking place that is called therapy.

Young & Gass (2007) reported that many (87%) of the programs in their survey described their programs as using "experiential" methods in their treatment process. Based on these findings, we seek to identify the types and relative use of "experiential therapies" for youth, families, social service and other agencies seeking treatment in private residential facilities. As researchers, we wondered what level of agreement could be found among clinicians in residential treatment programs regarding the term "experiential therapy." The goal was to move beyond terminology like adventure and wilderness therapy, which past research has shown to be too restrictive because of different misperceptions as to what each may represent in a treatment context (Gillis, 1992). It is reasoned that the use of experiential therapy may be less limiting, carry less stigma, and more accurately capture how physical activity, art, the therapeutic use of caring for animals, adventure activities, drama, and other forms of experience are used in clinical settings to help youth better understand the psychological and emotional issues underlying their need for treatment. Therefore, the purpose of this study was to explore the justification and potential for a clearer and more accurate understanding of what experiential therapy

is and how it is employed in residential programs. The study also sought to evaluate the premise that a significant number of youth may be receiving treatment best characterized as experiential therapy. The problem lies in the fact that few studies have empirically examined what the intervention is and how it may actually work. If that is the case, a better understanding of the key tenets of experiential therapy may be warranted.

Method

Subjects

In this pilot study, a primary association of residential programs for youth provided its mailing list (N=165) for an on-line survey using surveymonkey.com. Of the 165 emails, 11 emails were returned as either incomplete or out of date. Responses were received from 51 programs (33.1% of the 154 remaining programs). Table 2 displays program type. Comparisons with Young and Gass (2007) and NATSAP membership from 2007 indicate that the responses received in this pilot study are closely aligned with membership and provide an adequate sample.

Table 2. NATSAP member programs presented by program types.

Program Type	N	%	Young & Gass (2007)	NATSAP
Residential Treatment Center	21	41.2	33.3%	37%
Therapeutic Boarding School	13	25.5	23%	21.0%
Outdoor Behavioral Health/ Wilderness	11	21.6	20.7%	22.0%
Home-Based Residential	2	3.9	2.3%	2.8%
Young Adult	2	3.9	5.7%	5.0%
Transitional Independent Living	1	2.0	5.7%	2.2%
Other	1	2.0	0%	0.6%
Total	51	100.0	100%	100%

Instrument

The survey was designed to elicit responses that addressed the nature and degree to which each program utilized experiential therapy. Initial items asked brief demographic questions to be used to compare the sample developed in the study to Young and Gass' (2007) sample. Because the study was exploratory in nature, a series of open ended questions then asked respondents to describe: a) the

theoretical approach which guides the program's therapeutic process, b) a yes/no question that straightforwardly asked if they believed their approach was "experiential," (if stated no, the respondent was then directed to not complete the rest of the questionnaire) 3) an open-ended question about how their program was experiential, 4) whether the respondent believed that experiential therapy was tangential, adjunctive, or primary in its use in treating client issues, and 5) a series of questions that asked them to explore how experiential therapy was put into practice in their program. A copy of the survey is included in the Appendix.

Procedure

The on-line survey was distributed from Survey Monkey (www.surveymonkey.com) via email to a program list provided by the National Association of Therapeutic Schools and Programs (N=165). The survey was emailed to each contact person for the organization with instructions to have the clinical or program director fill out the survey. A reminder was sent two weeks after the original email and a final reminder sent one week later.

When asked if they were experiential, a significant majority stated that yes, they did consider their approach to be experiential therapy (88%, n = 46). We then included in the dataset only those that responded yes. We also asked them whether experiential therapy was 1) primary-first in importance and direct and immediate in its utilization (33.3%), 2) adjunctive--an additional component of treatment used in conjunction with more traditional models (64.4%, or 3) tangential--indirectly related to treatment and used more as a recreational outlet for students (2.2%)

To explore the meaning of the term "experiential therapy," we asked each respondent a series of four questions that provided structure and enough latitude to elaborate on specific aspects of how experiential therapy is integrated into their therapeutic approaches. The four questions were: 1) What psychotherapeutic approaches are utilized by your program? 2) Please describe how your therapeutic approach described above is experiential; 3) Briefly describe how experiential therapy might be used in the beginning phase of your program to work with a student in your program; and 4) What are the tangible benefits from experiential therapy that would not otherwise be achieved through more traditional modes of therapy?

Due to the exploratory nature of the study, responses to these questions were analyzed using qualitative analysis techniques. Each question was initially coded using open and pattern coding techniques using guidelines proposed by Miles and Huberman (1994). Consistent coding procedures were used throughout the analysis phase to maintain reliability. After an initial pass through the data, a series of open or descriptive codes were developed that were then pattern coded into different illustrations designed to capture the meaning inherent in the data. Reviews of coded responses by qualified academicians and practitioners were used to establish credibility in the data (Erlandson, Harris, Skipper, & Allen, 1993).

Results

A total of 46 programs who defined themselves as experiential responded to the question asking them to describe their therapeutic approach. Table 4 reports pattern coded responses to the question with associated descriptive codes and an example response. Each of the pattern codes were entered into the SPSS database as a descriptor to conduct frequencies on the number of programs that referenced that specific code. For example, the majority (85%) of the program respondents described their therapeutic approach as eclectic and referenced several different psychotherapeutic models as influencing their approach to working with their students (See Table 3 for list of psychotherapeutic models and theories referenced). It is clear that the programs therapeutic approaches are informed by a wide variety of theories and reflect an integration of these theories to best meet the needs of their students. Three programs cited a specific model that framed their approach [for example, Positive Peer Culture developed by Vorrath & Brendtro (1985)]. Only one program referenced a specific model that was not based in the traditional psychotherapeutic literature or domain. It is important to note that this was an open-ended question asking respondents to describe their approach. The coded responses reflected how respondents answered the question using terminology and meaning inherent in their answers. Fewer programs referenced addictions or recovery theory guiding their primary therapeutic approach (17%), and slightly more than 20% referenced skill development.

Table 3. Pattern and descriptive codes referencing question asking respondents to describe their psychotherapeutic approaches.

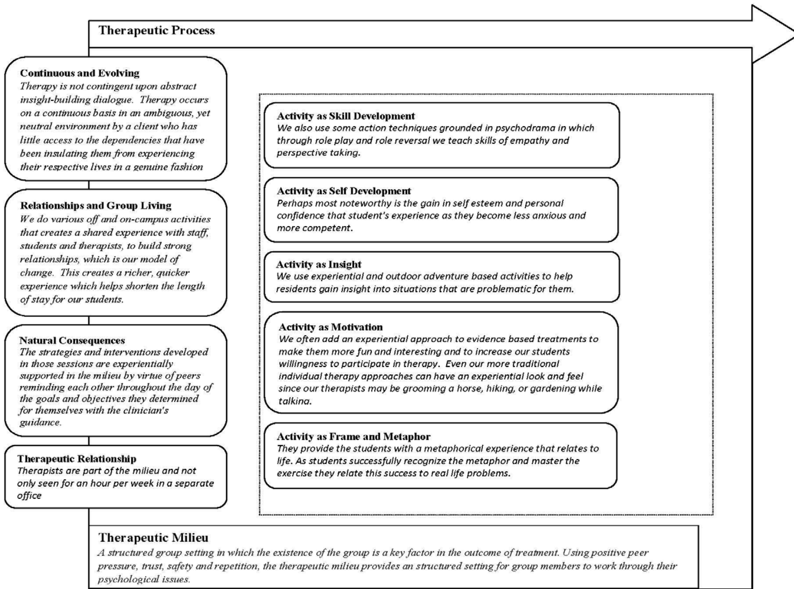
Theme	Descriptive Codes	Examples
<u>Eclectic</u> *Psychotherapeutic approach is referred to as eclectic or is described as eclectic in a milieu oriented system*	-Dialectical -Existential -Family systems -Cognitive behavioral -Gestalt -Behaviorism -Rational emotive -Adlerian -Motivational interviewing -Narrative -Reality Choice theory -12-step -Object relations-Transactional analysis -Solution focused -Positive psychology -Ordeal -Nutritional -Insight oriented -Social constructivist	*Therapeutic milieu, cognitive behavioral treatment, dialectical behavioral therapy, group therapy, brief therapy, adventure / wilderness therapy, and family systems approach.*
<u>Specific Models</u> *Reference is made to a particular and specific model that guides the approach*	-Relational attachment model -Positive peer culture -Token system and levels -Non-punitive -Good lives model	*Our over-arching treatment modality is the Positive Peer Culture developed by Vorrath & Brendtro. Students participate in Group, Individual and Family therapy*
<u>Alternative Model</u> *A reference is made to an alternative psychotherapeutic approach best defined as alternative, or not based in mainstream psychotherapy*	-Outdoor Adventure Therapeutic Model -Emotional growth -Equine -Canine -Creative arts -Service learning -Adventure -Wilderness -Drama	*Canine program teaching students about boundaries, discipline, communication, caring, and empathy. Students have the opportunity to bond and attach with a canine and even adopt it and take it home with them. creative arts--art, dance, poetry, etc.*
<u>Skills Based</u> *References an approach that develops psycho-educational skills* *Specialty Groups* *A reference is made to the creation of specialty groups based on student issues*	-Social skills -Emotional growth -Family education -Leadership -Parent instruction	*Cognitive therapy, drama therapy, equine therapy, behavioral therapy, rational emotive therapy, choice theory, attachment theory, and social skills training*
<u>Specialty Group</u> *A reference is made to the creation of specialty groups based on student issues*	-Adoption -Trauma recovery -DBT -CD or substance	*We provide group therapy 3x/ week, including traditional group process, and some specialty groups (i.e. DBT, adoption, trauma recovery, CD recovery, etc.)*

Defining Experiential Therapy in Practice

When asked to describe how their approach was therapeutic, respondents drew from a variety of theory and provided examples in practice that illustrated how experience and activity comprise the key pillars of what is meant by experiential therapy. Figure two presents pattern codes illustrating how respondents spoke of experiential therapy. Two key themes emerged from their responses: 1) that experiential therapy is utilized to developa certain treatment milieu that facilitates therapeutic factors reasoned to effectuate change, and 2) that experiential therapy was described as activity implemented throughout the therapeutic process to elicit responses learned by the student that can be used in individual, group or family-based therapeutic discussion.

The therapeutic milieu, defined by respondents as comprising the day to day cultural therapeutic environment of each residential facility including staff, therapist, and student interaction, is facilitated by four factors reasoned to help develop this milieu through the intentional practice of experiential therapy. For example, one of the factors titled “Continuous and Evolving” references the idea that group living and shared direct experience allow, in the words of the respondent “Therapy (to) occur on a continuous basis in an ambiguous, yet neutral environment by a student who has little access to the dependencies that have been insulating them from experiencing their respective lives in a genuine fashion.”

Figure 1. Illustration of coded responses to responses describing how experiential therapy is practiced in respective programs.



Relationships and Group Living, Natural Consequences, and Therapeutic Relationship were themes that captured how clinicians viewed experiential methods as a way to help adolescents develop relationships in an unstructured way. These three factors capture the essence of how experiential activities are used to develop the therapeutic social environment critical to social and emotional learning and skill development. For example, in reflecting on the "Relationships and Group Living" factor, one respondent stated, "the strategies and interventions developed in those sessions are experientially supported in the milieu by virtue of peers reminding each other throughout the day of the goals and objectives they determined for themselves with the clinician's guidance. Therapy does not solely take place in the clinician's office. Through peer support, therapy is taking place in Algebra class, or on a walk." This comment captures the essence of the unstructured nature of the milieu, the focused intent of experiential interventions, the peer support that accompanies the activities, and the therapeutic guidance provided by licensed (or licensed eligible) clinicians.

As Figure 1 illustrates, as the activities and processes unfold in the milieu, respondents clarified a variety of objectives underlying the use of activity and experience. These include activity for self development, to enhance motivation, to reflect on and use as metaphor in more directed individual and group sessions, and as specific tools for insight into an issue with which a student may be confronted. For example, one respondent stated "the emphasis of our experiential approach is to help residents make effective and appropriate choices, as we relate and re-create the experiences in a variety of experiential settings in order to help them gain experience, insight and understanding." In this way, activity, experience, and the subsequent personal and interpersonal learning that occurs are re-visited and utilized to help make more abstract and tangential concepts, ideas, and understandings, which are often difficult for adolescents to relate to, more real. One respondent described the value of re-visiting the experience. "In order to get the most out of this program, we use (discuss) these experiences in group process after the fact, of course, and have found the "experience" to be invaluable to our students progress through the years."

Benefits of Experiential Therapy

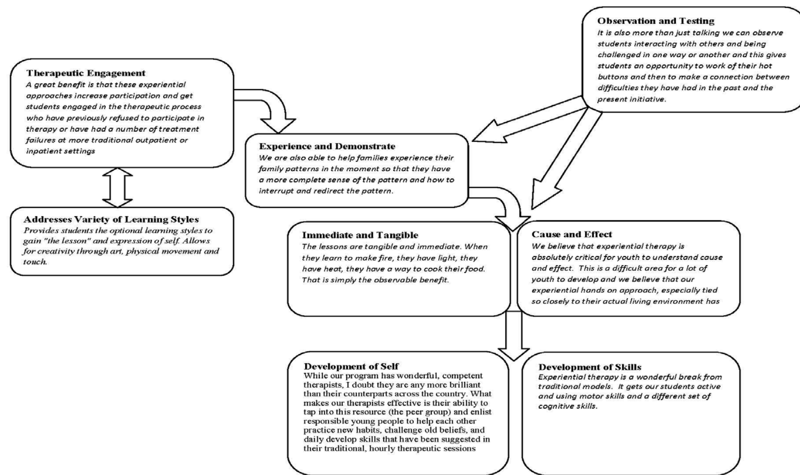
Figure 2 illustrates a conceptual model of the benefits of experiential therapy from the perspective of the respondents. Interestingly, the coded responses did not evoke discussions of skills and therapeutic learning in a more direct sense, though these types of outcomes were mentioned. The meaning captured in their explanations of the benefits was more focused on the benefits of the therapeutic process, rather than just describing a variety of therapeutic outcomes, which in the development of the survey was the intent of the question. The model begins with the idea that a student's willingness to engage in therapy is enhanced through the use of activity and experience. Coupled with this idea is that the approach addresses multiple learning styles, including visual, audio, kinesthetic, and spatial learners. Referenced several times was the way that kinesthetic learners are served through this medium and thrive in the environment. One respondent stated, "in addition some of our students are kinesthetic learners thus therapy becomes more than just an intellectual exercise, it becomes physical and emotional exercise."

experiential activities produced "Immediate and Tangible" learning opportunities and feedback and allowed them to utilize this feedback in a direct way. Linked to this idea, the process also developed a clear understanding for students the "Cause and Effect" of their actions and emotional energy on people and place. As one respondent stated "The student is able to learn how to take immediate accountability and ownership for his emotions and choices after a stress response elicited by an experience which has occurred within the culture of support provided by the peers and staff." During this process, staff and therapists from the programs are able to observe and work with students in real time and witness directly the process and outcome from student interaction. As Figure 2 illustrates, this can include the development of an intentional activity for a student, and the observation of the process and outcome of that process. This was seen as very beneficial and not as easily facilitated in more traditional settings. As one respondent states:

> "*We have students in our program from most of the major metropolitan areas of the United States. I am quite certain each of these cities have an adequate number of competent clinicians. Yet, time and again we receive students whose parents indicate they have been in traditional individual therapy to no avail. While our program has wonderful, competent therapists, I doubt they are any more brilliant than their counterparts across the country. What makes our therapists effective is their ability to tap into this resource (the peer group) and enlist responsible young people to help each other practice new habits, challenge old beliefs, and daily develop skills that have been suggested in their traditional, hourly therapeutic sessions."*

Finally, therapeutic outcomes emerge from this process in the form of intra- and inter-personal skills and improved physical well-being, broadly defined in Figure 2 as the "Development of Self" and the "Development of Motor Skills". The latter code was referenced by several respondents and was viewed as a unique and critical aspect of the process. These types of benefits were seen as integral to the full development of the student, especially given the adolescent stage of their lives.

Figure 2. A conceptual model depicting the benefits of experiential therapy to students in residential settings.



Case Study Vignettes from Respondent Perspectives

What follows are four case studies representing each of the program types based on responses from the question asking respondents to describe how experiential therapy would be used in the initial stages of a program working with a typical student. Of note is that many respondents stated that there is no such thing as a typical 15-year old in our program. Despite these limitations, most respondents provided an example of how the therapeutic process would be initiated at their respective programs using experiential therapy. In this way, a richer discussion of the previous discussion is presented and illustrated with fictitious youth in hypothetical situations, using very real interventions.

The four program types are: 1) residential treatment centers; 2) therapeutic boarding schools; 3) outdoor behavioral health; and 4) other, which comprises a variety of program types not easily categorized.

Residential Treatment Center. Bill, a 15 year old student at a residential treatment center is struggling with mood regulation related to attachment and trauma issues. He is adopted and struggling with questions about why he was adopted and having self-worth and identity issues. As a result, one program found that Bill was acting out sexually and defiantly, as well as having a past dominated by

substance abuse.

In the first phase of the program, Bill would work on disclosures and breaking down resistance to being placed in residential treatment. Early treatment (the first 60-90 days) would revolve around what Bill is learning from his peer group about autonomy and personal responsibility. One survey respondent gave the following description of the process within a residential treatment center.

Most teens (like Bill) have tried to gain autonomy by virtue of irresponsible behavior driven by irrational beliefs about themselves or the world. Students may have been involved in traditional therapeutic approaches that they rejected, or those traditional hourly sessions were insufficient to influence students from the negative peer associations they were seeking. Many of them sought those negative associations due to our human nature's compelling force to belong to something, and for most those negative peer associations negated the effects of the best clinicians. In our Positive Peer Culture model, we first begin developing a positive peer association that challenges them to help each other resolve their problems under the guidance and direction of responsible, care-giving adults. A group of nine teens in a cottage will not evolve into a Positive Peer Culture merely on it's own. Students are led to uncover their own intrinsic value for helping others... not by virtue of punishment or external reward, but because they discover they feel better about themselves when making an altruistic contribution into the lives of other students. As they begin to develop that value to help others, then individual therapy begins to take place and that therapy focuses on the resolution of personal problems by assignments to help others within the peer group.

Therapeutic Boarding School. Therapeutic-based boarding schools often cater to students transitioning from other interventions. One program said, "the beginning phase of our program is essentially geared to help students transfer the skills and insights acquired through a wilderness intervention to a new, larger, more psychologically complex environment. Part of the way experiential therapy is used is to acclimate students to the program and peer group.

Rachel, a 15 year old student diagnosed with bipolar disorder would complete a confidence ropes course with her peer group on a two day outing. In the beginning of treatment, activities would be sequenced to start small and grow increasingly complex requiring

greater levels of teamwork and peer interaction to complete.

Rachel would also engage with her team by participating in chores and team activities on and off campus. A team mentor would be assigned on the first day to help orient her during the coming days and weeks of the program. The concept of "team" is described as being the on-campus "family" and relevant "parental" staff who engage students in all aspects of daily life: chores, classes, sports, group therapy and community living experiences and wilderness challenges. One respondent noted, "every activity that we do has a specific therapeutic purpose and objective, and we work very hard to ensure that we integrate personal growth goals, academic skill development, and recreational / healthy risk-taking into each activity or part of the program." This approach avoids behavioral techniques and instead focuses on building strong relationships and processing experiences so students learn to process "experientially" what they are going through instead of learning to expect a reward or punishment for their choices. This highlights how students like Rachel are receiving therapeutic interventions through daily experiences, whether in the classroom, outdoor adventures, or having dinner with peers or the therapist. Students like Rachel appear to respond very well to the active, real-life situations that can be processed and integrated into her mental models.

Outdoor Behavioral Healthcare. Outdoor behavioral healthcare programs involve wilderness expeditions, requiring the initial phases of the treatment process to be focused on orientation to the group and program and the learning of a variety of skills to become more proficient with backcountry travel. As one respondent stated, "a typical 15 year-old student would come to our program reluctantly but willingly." A significant factor in the early phases would be acceptance of the student by the group and the use of peer support to help ease the student into their experience. Staff typically steps back and lets more experienced students work to orient the student.

Johnny has a history of violent outbursts with his parents, substance use issues, failure in several schools, and a lack of progress in working with his most recent counselor in an outpatient setting. He would spend his first few days learning about how the expeditions work within the program and the roles that each student has in the success of the team on expedition. He would be encouraged to see

he is needed in the program to help the team and himself grow. Task specific skills he would be working on would include understanding the nuances of navigating, backcountry cooking, and playing the role as a leader of the day. Common topics in group discussions around meals and therapy sessions would focus on the therapeutic role of the group as a family system.

In their first therapy session, Johnny would be given letters from his parents that highlight his strengths and specifically do not focus on his weakenesses nor reasons why he may be in treatment. This strengths-based approach provides an opportunity to build on the good inside Johnny and re-think the fractured relationship he may have with his parents. In this way, treatment is not seen as a punishment, but for a chance to rebuild their relationships. Johnny would also be given the chance to explore how making fire or having a "new beginning" applies to not only life in treatment, but more importantly at home with his family and friends. The next steps would be for Johnny to come to an understanding of why he is treatment, write this in a letter to his parents, and ask them for their perspective on why he needed treatment. This discourse is the beginning of the healing process for families and sets the foundation for reconciliation.

Other Types of Settings. The other type of setting chosen to illustrate a vignette would be a ranch that utilizes equine therapy in helping students address their issues. Sarah, a 15 year old, is having personal identity and self worth issues. Consequently, she has been acting out sexually, has been increasingly violent with her recently divorced mother, and has issues with substance abuse. Sarah has seen a social worker through local community services for years, but has not been making any progress. Her mother has become increasingly worried about her personal safety. Because the program utilizes a family systems approach, Sarah would attend a multi-family group with her parents and other families and participate in initiative activities that focus on family reconnection. Sarah and her mother (her father is completely out of the picture and refuses to participate) would process the meaning of the experiences with therapists and discuss their feelings about the activities with their peers their parents. An equine-based activity utilized by the program in the first week would be to use the horses to help Sarah gain insight into her current situation. Sarah has revealed in her family meeting that she is still

very resistant to therapy and change and feels she has been placed in the program as punishment for her previous behaviors. The staff at the program has Sarah go into an arena with 4 to 6 horses and challenges her to "catch" a horse with who she feels she has the potential to form a lasting bond. The horses are resistant to being caught, and are very elusive. The experience is exhilarating, frightening, and challenging all at once. Sarah eventually corners a horse using soothing language and slow and steady patience. From that experience, Sarah, in working with her therapist at the program, begins to gain insight on their own resistance to the first and most difficult phase of treatment, and begins to slowly open up about her adoption issues and her relationship with her mother and previous relationship with her father.

Discussion

This paper reviewed the relevant literature on the adolescent behavioral healthcare service industry operating in the United States and Canada and discussed the well-documented historical demand for services. A discussion of best practices in residential treatment and movements to advocate for best practices and ethical treatment for adolescents and their families was presented. An estimation of the number of adolescent residential treatment programs and subsequent number of students in residence based on data acquired from national accreditation agencies was given. Finally, a presentation of preliminary results from a member survey of a national association was presented. The survey was guided by the question: What is experiential therapy and what does it look like when practiced with adolescents in your program. The following issues emerged from this study which guide this discussion: 1) the persistent and growing problem of a lack of healthcare services for adolescents, 2) the growing movement and subsequent discussion on the role that residential treatment plays on the continuum of available healthcare services for adolescents, 3) the role that direct and intentional experience play in the treatment of adolescents in residential settings, and 4) the need to better understand how experience and activity are integrated within existing evidence based practice in residential settings.

Access to community-based behavioral healthcare services for adolescents has been a persistent and growing concern. The "continuum of care" talked about by behavioral healthcare experts

that consists of services in schools, outpatient, inpatient, day treatment, and accessible residential facilities appears to be out of reach for families seeking treatment alternatives. The demonstrated historical demand and current lack of services make it highly likely that innovative programs, and more importantly, effective innovative programs, will be increasingly utilized by families in search of help for their children. As programs continue to evolve and adapt to meet this growing demand, an increased understanding of the therapeutic approaches being employed by such programs will (a) help researchers in their attempts to evaluate programs that utilize experiential methods in treatment, (b) aid families who are faced with a dizzying array of barriers and challenges in finding the right program for their child, and (c) educate referring mental health professionals in helping them find and place adolescents in appropriate programs.

We estimate approximately 1,500 known residential treatment programs for adolescents currently operating in the United States and Canada. These programs seem to fill an important need in the lexicon of mental health services. An interesting finding in this research project has uncovered what appears to be a growing movement, pushed by organizations like ASTART, that question the value and role of residential treatment services for adolescents and their families. This is surprising given the lack of services available in general, and the fact that many of these programs are private pay, and are driven by market conditions and demonstrated need by consumers. The rhetoric accompanying this movement is predicated on the idea that youth should never be taken out of their homes, and that treatment should be focused on working with families and youth in their homes and neighborhoods. As one author stated, "Instead of removing teens from their environments, therapeutic approaches like Multi-Systemic Therapy (MST) are out in the trenches with teens and families in their own environments, a strategy that works and saves the lives of teens" (Van Orden, 2009, p. 3). Though treatment approaches like MST are appropriate for certain types of youth, MST is an extremely rigid program that requires absolute adherence to the model. In most cases, only families that qualify for government support have access to this intervention, which leaves most middle and upper socio-economic status families with few options other than outpatient treatment (which most have tried prior to turning to residential treatment). Moreover, most research shows that interventions, like MST, are no more effective

than residential treatment models when directly compared in research studies (Littell, Campbell, Green & Toews 2005). An improved understanding of what types of treatment approaches are utilized in residential programs, and the degree to which they help address well documented barriers and stigma associated with traditional treatment approaches, and meet the demand for adolescent healthcare services, is needed so a more informed and less reactive discussion can take place.

We hypothesize that if each program annually served 250 students a year, then approximately 500,000 adolescents a year may be treated by in residential settings. It is difficult to compare these figures to the literature, because as Freidman (2009) states, "We were dismayed when they (GAO) were no more successful than others in coming up with estimates of the number of youth in private residential placements" (p. 3). Despite these difficulties in estimating the utilization of these services, it is clear that our study shows a significant number of programs do indeed utilize direct experience to enhance their therapeutic approach. Continuing to discuss how practitioners utilize experience and integrate it into existing therapeutic modalities appears to be an area that could shed light on what may or may not be more effective. If 'research therapies' that are tested and disseminated through strict adherence to manuals and protocol are not what is being practiced on the ground by creative and well intended therapists, then research and evaluation should focus on what actually is being implemented in these environments. This inquiry would strengthen our understanding of how to work with youth, and what might really constitute best practices.

Our survey focused on the following four questions:
1) What psychotherapeutic approaches are utilized by your program? 2) Please describe how your therapeutic approach described above is experiential, 3) Briefly describe how experiential therapy might be used in the beginning phase of your program to work with a student in your program, and 4) What are the tangible benefits from experiential therapy that would not otherwise be achieved through more traditional modes of therapy. The sample of 51 respondents, though small (33%) appears to match the percentages of program types and geographic locations of a previous survey and of figures of the national association. We consider the sample valid. There were 46 programs that responded to the question of whether their therapeutic approach was experiential.

From the responses of the 46 we hypothesized the following agents of change in this model of activity-based experiential treatment.

The therapeutic *milieu* is continuous and evolving. It involves relationships among and between members of a group. This milieu often involves natural consequences and therapeutic relationships that are on-going and integrated into treatment more than in traditional approaches. While the milieu describes several similarities with group therapy, the continuously evolving, naturally consequencing environment of experiential therapy described here appears to be unique to approaches that make use of challenge courses, wilderness, or animals.

The *process* of this form of experiential treatment centers on activity. Activity provides skill development, self development, insight, and motivation. Activity can provide a frame to experience and serve as a kinesthetic metaphor for life. The centrality of activity within respondents' answers set this form of experiential therapy apart from others in its ability to access clients with various learning styles and its de-emphasis on verbal aspects paramount in traditional approaches.

The interaction of the milieu and the process provide a dynamic, active, often kinesthetic, model of experiential treatment that needs evidence to support or disprove it. Key questions that future research could address include: Are all elements of the milieu necessary? If a student or client is impacted by activity in only one of the ways mentioned, is this sufficient for activity-based experiential therapy to be successful? How might this approach be researched? What if students who had previously been involved in residential treatment where experiential methods took place were asked to identify which elements of their experience provided "triggers" for change in their behavior? What if these responses began to cluster among the same (or different) aspects of this model that has been proposed? This pilot study sheds some light on how experiential methods are being used in residential treatment. It also raises the question of how a larger number of residential programs may or may not also be utilizing experiential approaches. Further study of a larger sample can potentially lead to a more informed discussion of how practitioners are working with adolescents and their families in residential settings to create therapeutic change through experiential methods.

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Appendix A. Survey

1. CONSENT: I agree to be a participant in the research titled "Amer.Psyc.Assoc/ NATSAP research study", which is being conducted by Keith C. Russell and Lee Gillis, who can be reached at 360.XXX.XXXX or 478.XXX.XXXX. I understand this participation is entirely voluntary; I can withdraw my consent at any time and have the results of the participation returned to me, removed from the experimental records, or destroyed.

- Yes
- No

2. What is your primary program type?

- Residential Treatment Center
- Home-Based Residential
- Emotional Growth Boarding School
- Young Adult
- Boarding School
- Transitional Independent Living
- Therapeutic Boarding School
- Outdoor Behavioral Health/Wilderness

Other (please specify)

3. In what year did your program begin operation?

4. In what state or province are you located (2 letter abbreviation)?

5. Is your program accredited?

- Yes
- No

6. Are you licensed in your state?

☐ Yes

☐ No

7. What is the approximate percentage of each gender served: (add to 100%)

Females ☐

Males ☐

8. What is the average number of clients/students served annually (over the past three years)?

☐

9. What is the maximum enrollment (capacity) for your program?

☐

10. What is the average length of stay for a client/student?

☐

11. Do you serve clients over 18 years of age?

☐ Yes

☐ No

12. Do you serve clients between 13 and 18 years of age?

☐ Yes

☐ No

13. Do you serve clients 12 years old or less?

- Yes
- No

14. What psychotherapeutic approaches are utilized by your program?

15. Do you consider the psychotherapeutic approach described above "experiential"?

- Yes - please proceed
- No - please skip to the bottom of the page and click submit

16. Please write 1-3 sentences to describe how your psychotherapeutic approach is "experiential."

17. In your program, is experiential therapy..

- Tangiential - Only indirectly related
- Adjunctive - Additional, add-on; an approach used at the same time as other treatments
- Primary - First in importance; direct and immediate

18. In the beginning phase of your therapeutic program, how would experiential therapy be used to treat a typical 15 year old student. Briefly describe the client and provide an example of 1-2 sessions or activities.

19. What tangible, observable benefits (if any) do you see from the use of experiential therapy that would not otherwise be achieved through traditional modes of therapy?

20. How important do you think experiential therapy is to your students/client realizing their therapeutic goals?

- Not important
- Somewhat important
- Important
- Extremely important