A NARRATIVE STUDY DESCRIBING THE TRANSITION FROM RESIDENTIAL TREATMENT AS A CHILD: AN ADULT PERSPECTIVE

Alison Marie Vogelsang

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A NARRATIVE STUDY DESCRIBING THE TRANSITION FROM RESIDENTIAL TREATMENT AS A CHILD: AN ADULT PERSPECTIVE

By

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A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy

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In the Graduate School
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ABSTRACT

To date, the literature sorely lacks empirical research exploring treatment outcomes among children in residential treatment centers (RTCs). Consequentially, there is an increasing demand for more studies examining such outcomes, particularly as they pertain to an individual’s experience leaving an RTC. There is even less research exploring the perspectives of individuals who resided in an RTC as a child due to the vulnerable nature of this population and difficulty in accessibility. The transitional period is believed to be a salient component impacting treatment outcomes, yet little is known about how this component of residential treatment is experienced and whether it impacts individuals long-term. The purpose of the study was to understand how adults who transition out of an RTC as a child recounted their experiences before, during, and after their transition. The study was guided by the following research questions: “How do adults who transitioned out of an RTC as a child recount their experiences before, during, and after their transition?,” “Which lived experiences do these adults perceive to have been the most impactful in their life trajectory?,” and “In what ways have these adults integrated their experience leaving an RTC as a child into the broader context of their life story?” Six participants who resided in an RTC as a child for at least six consecutive months produced a total of 26 hours of interview data. They recounted their experiences associated with residing in and transitioning out of an RTC as a child and eloquently told their stories. Data was transcribed, coded, and written in narrative and thematic form for the purpose of extrapolating meaning from the stories. Six narratives were written, and five themes were identified through data analysis. Identified themes include the following: learned and used coping skills, changed opinion about mental health treatment across time, increased understanding and awareness of mental health, developed and maintained impactful relationships, and experienced difficult transition from the RTC. Validation and reliability procedures were utilized to ensure integrity and legitimacy of the findings.
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Introduction

There has been an increasing demand for research studies examining the role of youth’s transitional experience from residential treatment centers (RTCs) to their next placement (Leichtman & Leichtman, 2001), and in particular need are studies exploring this experience from a first-hand perspective. The literature largely defines a “placement” as an out-of-home living arrangement such as foster homes, adoptive homes, group homes, RTCs (Unrau, 2007), a Juvenile Detention Center (JDC), hospital, or another treatment facility. RTCs are generally defined as a facility that provides basic needs for the clients (children or adults) along with mental health treatment and a therapeutic environment (Bates et al., 1997). In general, children in RTCs are difficult to study because their lives tend to be transient due to frequent change in caregiver custody and placement in various out-of-home settings (Pottick et al., 2005).

Furthermore, there is limited research involving children in RTCs due to difficulty accessing this population. Children are considered a vulnerable population to research and this vulnerability is heightened due to frequent histories of abuse, behavioral and emotional difficulties, and chaotic environments commonly experienced by children in RTCs.

In addition to a limited amount of outcome research and follow-up conducted among this population, there are also an increasing number of children experiencing emotional disturbance being referred to RTCs (Asarnow et al., 1996; Blader, 2004; Connor et al., 2002). Published studies have explored the general experiences of children in residential treatment programs (Chama & Ramirez, 2014; Gibson, 2008; Heinrichs, 1999; Johansson & Andersson, 2006; Scholom, 2018; Tarantino, 2002), family or parent experience(s) of admitting their child to a RTC (Brown et al., 2018; Goldberg, 1991; Johnson, 2019), the experience of RTC staff members (Adelman et al., 2015; Demery, 2006; Hudzik, 2006; Hyatt-Burkhart, 2011; Smith, 2018), or a
specific aspect of the RTC programming such as experience in psychotherapy (Qureshi, 2018), psychopharmacological interventions (Foltz & Huefner, 2014), or educational programming (Allison, 2013; Day et al., 2017). However, there are few studies that have explored the lived experience of preparing for and participating in the transitional process from an RTC to another placement or to their home of origin. The literature also indicates that the transition from an RTC to the next placement may be a key factor in long-term success (Vogelsang, 2018), which further supports the importance of learning more about this phenomenon.

The purpose of this study was to collect stories from adults who transitioned out of an RTC as a child. Use of adult participants allowed for participant reflection on their pre and post RTC discharge, and how this transitional period impacted their life trajectory. Of particular interest was the participant’s experience transitioning and their perspective about the process. Characteristics of RTC’s and those commonly exhibited by children in RTC’s are discussed below as well as review of the literature regarding transitional periods out of residential treatment. Improving knowledge about the experience of transitioning from an RTC will ultimately inform treatment delivery and outcomes. This study addressed these questions through use of a qualitative, narrative design (Kim, 2016; Mishler, 1995; Polkinghorne, 1995; Reissman, 2008).

**Literature Review**

The broader literature associated with the topic will be discussed prior to presentation of the methodology and study findings. More specifically, the nature and purpose of residential treatment centers (RTCs) is described in addition to their parallel with inpatient psychiatric facilities (IPFs). Common characteristics often observed among children enrolled in RTCs such as aggression and/or child maltreatment and trauma is also discussed. Discussion of literature
pertaining to treatment outcomes is discussed, which includes readmission rates and length of stay in treatment. Then, the nature of transitioning out of an RTC will be described in addition to adult perspectives pertaining to childhood experiences. Finally, results and implications associated with a preliminary study are presented in Appendix C and inform the study’s purpose and research questions.

**Residential Treatment Centers**

An RTC is defined as a facility that provides basic needs for the clients (children or adults) along with mental health treatment and a therapeutic environment (Bates et al., 1997). More specifically, the National Mental Health Services Survey (N-MHSS; 2021) defines RTCs for children as “facilities not licensed as psychiatric hospitals that provide individually planned programs of mental health treatment in a residential care setting for children under age 18” (p. 7). Child RTCs must “have a clinical program that is directed by a psychiatrist, psychologist, social worker, or psychiatric nurse who has a master’s or doctoral degree” (N-MHSS, 2021 p. 7). The N-MHSS definition is broad which allows for many different structures of RTCs to fall within compliance. Therefore, there appears to be a lack of a clear RTC definition which emphasizes the importance of conducting research in these settings (Brady & Caraway, 2002). RTCs are also designed to serve children with a diverse range of clinical problems including substance abuse, neurodevelopmental disorders, behavioral and emotional disturbance, among others (Preyde et al., 2019). They differ in their treatment philosophy, level of restriction, and populations served, and account for one type of out-of-home treatment setting designed for children.

In general, there are high numbers of children placed in out-of-home treatment every year (Brady & Caraway, 2002) despite child RTCs representing approximately 5.0% of all mental health agencies (N-MHSS, 2021, Figure 1). According to the Substance Abuse and Mental
Health Services Administration (SAMHSA; 2019, Table 9.2A), approximately 683,200 adolescents between ages 12 and 17-years-old were served in either an RTC or IPF in the year of 2018. Thus, RTCs fill a vital role in providing necessary mental health care to children and adolescents who are unable to appropriately function in a home-like and/or public school setting as children with the most severe problems are being placed in these settings (Baker et al., 2005). The precipitant to RTC admission is typically a breakdown in the child’s relationships and their caretakers’ ability to manage the child’s behaviors (Gallagher & Green, 2012). More specifically, one study found that 72.0% of children in RTCs were referred and admitted due to threat of harm to self or others while approximately 20.0% were admitted due to behavioral disturbance (Singh et al., 1994). When admitted to an RTC, children with severe emotional and/or behavioral disturbance are provided with education and mental health services.

Historically, utilization of RTCs for children has been controversial because the effectiveness and cost versus benefit of such treatment is debated (Barth et al., 2007; Bates et al., 1997; Park et al., 2009). RTCs house residents for approximately six months to one year or longer (Baker et al., 2003; Preyde et al., 2019) and provide less intense care than a psychiatric hospital, yet more intense care than outpatient therapy services (Baker et al., 2003; Bates et al., 1997). Concerns also stem from the Individuals with Disabilities Education Act (IDEA), passed in 1975, which states that children should be provided education in the “least restrictive environment” possible (Howard, 2004, p. 167). This philosophy is also applied to children who are removed from their home.

More specifically, deciding whether to remove a child from their home and place them in an RTC due to emotional and/or behavioral concerns is a very impactful decision to both the child and their family. Approximately 48.9% of children are placed in intense and restrictive
settings as their first out-of-home placement without trying alternatives (Barth et al., 2007). Many professionals argue that other alternatives such as intensive in-home services should be exhausted before children are placed in RTCs (Frensch & Cameron, 2002). However, deterring out-of-home placement may also result in an increased number of children being admitted to IPFs or juvenile detention centers (Lyons & McCulloch, 2006). Overall, the literature indicates that valid attempts should be made to provide the child with the support that they need while including their family in treatment and offering the least possible amount of restriction in their life (Frensch & Cameron, 2002; Kruzich et al., 2003; Landsman et al., 2001; Yampolskaya et al., 2013).

Treatment effectiveness is another issue that arises regarding RTCs. Effectiveness of treatment is often measured by use of differing subjective methods including reports by families of children enrolled in RTCs (Bates et al., 1997; Connor et al., 2002). For example, families often report improvements in their children’s functioning post RTC discharge. However, these reports typically differ from objective measures of improvement that consider the child’s contact with law enforcement or school suspensions (Bates et al., 1997). Obtaining consensus of what “better” means is difficult for RTC teams to determine (Connor et al., 2002), and can make their decision about discharge more challenging. Lastly, length of time in treatment is another factor associated with treatment effectiveness, and this is impacted by many different factors (Strickler et al., 2016).

In sum, there is little data collected from children who have been discharged from RTCs, especially as it pertains to the transitional experience of leaving the RTC. This indicates that there is more to learn about the effectiveness of RTCs on treatment outcomes (Bates et al., 1997), as we know the discharge process is an impactful factor. Conducting follow-up assessments with
children post-discharge also proves difficult due to the transient lives of this population and difficulty in accessibility. Thus, there is need for further research on treatment outcomes and the role of the transition out of the RTC.

Another type of out-of-home treatment setting utilized by children are IPFs which are defined as “facilities licensed and operated as state/public psychiatric hospitals, or as state-licensed private psychiatric hospitals that primarily provide 24-hour inpatient care to persons with mental illness” (N-MHSS, 2021, p. 6). Similarly, Medicare law defines an IPF as “…an institution primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients…” (Centers for Medicare and Medicaid Services, 2016, p. 11). Although the majority of individuals enrolled in IPFs are adults, individuals of all ages use these resources. Moreover, IPF enrollment among children tends to be controversial. Many professionals and policymakers argue that the cost of IPFs when compared to the treatment benefit is too high. However, there are many children and adolescents for which inpatient care is necessary due to safety concerns such as harm to themselves and/or others (Pottick, McAlpline, & Andelman, 2000). Overall, children’s length of stay (LOS) in IPFs has decreased over time which is thought to be associated with worsened outcomes (Pottick et al., 2000) and increases overall risk for future readmission (Fite et al., 2009).

Upon review of the literature, a comparison can be made between readmission rates in IPFs and readmission rates in RTCs since both classify as intensive out-of-home treatment available to children. Children are usually admitted to IPFs or RTCs when there are safety concerns (e.g., harm to self-and/or others, reckless/dangerous behavior, running away, etc.) and an inability of the child’s caregiver to manage the child's behavior. There are also differences between RTCs and IPFs in that RTCs provide long term, out-of-home behavioral health
treatment while IPFs provide acute behavioral health care with 24-hour medical care (Asarnow et al., 1996). Despite such differences, previous research conducted in both settings is discussed because both settings treat similar populations and have similar goals, allowing for comparisons to be drawn. In general, there is more research conducted among children enrolled in IPFs than among children enrolled in RTCs.

**Children in Residential Treatment Centers**

A sizeable body of literature has identified common characteristics among children enrolled in RTCs including the child’s history, psychiatric diagnoses, previous placements, and family structure (Brady & Caraway, 2002; Vogelsang, 2018). There are also certain factors associated with readmission and response to treatment including likelihood for success and capacity for aggression. Children at highest risk for initial admission to RTCs include boys, children who have experienced previous contact with Child Protective Services (CPS), children in foster care, children whose abuse cases were substantiated, children who suffer from mental illness, and children with multiple psychiatric diagnoses (Chung et al., 2008; Lanier & Rose, 2017; Patel et al., 2018; Yampolskaya et al., 2013). Moreover, a recent meta-analysis compared characteristics of children in RTCs with characteristics often observed among children in other types of out-of-home placements (Leloux-Opmeer et al., 2016). Results indicate that children with cognitive difficulties, severe emotional and behavioral disturbance, attachment disruption, history of abuse or neglect, low socioeconomic status, and those with family members suffering from addiction and/or mental health problems are more likely to be served by RTCs than by other placement settings.

Specifically, the majority of children enrolled in RTCs have experienced previous placement in IPFs, many different caregivers, a great deal of trauma and stress, and generally
chaotic childhoods with estimates ranging from 71.0% to 97.6% of children experiencing at least one traumatic event (Brady & Caraway, 2002; Briggs et al., 2012; Jaycox et al., 2004; Zelechoski et al., 2013). One study also found that approximately 80.0% of children in RTCs have experienced two or more out-of-home placements prior to their RTC admission (Connor, Doerfler, et al., 2004) with other estimates reporting an average of four out-of-home placements prior to their RTC admission (Leloux-Opmeer et al., 2016). Research also demonstrates that girls in RTCs who experienced childhood trauma are more likely to experience poor psychosocial functioning as emerging adults (van Vugt et al., 2014).

Children in RTCs and IPFs are also commonly diagnosed with a psychiatric and/or physiological disorders (Clemens et al., 2010; Leloux-Opmeer et al., 2016). The most pervasive diagnoses observed among this population is Conduct Disorder (CD) and/or Oppositional Defiant Disorder (ODD; Cederna-Meko et al., 2014; Zelechoski et al., 2013), which are both marked by forms of aggression (American Psychiatric Association, 2013). Other common diagnoses observed among this population include post-traumatic stress disorder (PTSD), reactive attachment disorder (RAD), substance use disorders (SUDs), attention deficit disorder (ADHD), and depression. One study using a residential sample demonstrated that almost all children (92.0%) received more than one psychiatric diagnosis and approximately 40.0% received physical diagnoses including asthma, obesity, cardiovascular conditions, and neurological disorders (Connor, Doerfler, et al., 2004).

Although children in RTCs endure significant hardship, there are many reasons why they are ultimately admitted. For example, the majority of children in one sample attributed their admission to an RTC as a result of their own actions (Brady & Caraway, 2002). Despite children often admitting to RTCs due to their caregiver being unable to manage their behavior, most of
these children have also endured hardship that is out of their control. Most of the problematic behavior displayed by children who require RTC placement is understandable upon consideration of contextual factors such as the child’s background and early life experiences. Moreover, social support for these children often varies due to chaotic early life experiences (Brady & Caraway, 2002). In general, there is variability throughout the literature concerning the types of adults that children in RTCs consider as trustworthy. Additionally, if a child’s family can be effectively counseled to provide appropriate support for the child after discharge from an RTC, the child is more likely to experience success (Henggeler & Sheidow, 2012).

**Aggression**

Aggression is one of the most common reasons why children are admitted to IPFs because it is associated with significant consequences for the aggressor, caregivers, and witnesses of the aggression (Crocker et al., 2010). More specifically, aggression is typically expressed by approximately 58.0% of children enrolled in RTCs (Connor, Doerfler, et al., 2004). As mentioned, ODD is a common diagnosis among children admitted to IPFs (Rice et al., 2002) and RTCs (Cederna-Meko et al., 2014). ODD is characterized by anger, loss of one’s temper, defiance of rules and authority, and displays of spitefulness and vindication (American Psychiatric Association, 2013). Children diagnosed with ODD are more likely to be placed in facilities that provide a higher level of care, such as RTCs (Cederna-Meko et al., 2014) when compared to children without an ODD diagnosis.

CD is another common diagnosis observed among this population (Yampolskaya et al., 2013) and is marked by aggressive behavioral patterns directed towards people, animals, and/or property. CD is associated with behaviors such as destruction of property, deceitfulness or theft, and serious violation of rules (American Psychiatric Association, 2013). Children with CD or
other disruptive behavior diagnoses are also more likely to exhibit aggression necessitating restraint when compared to children without such diagnoses (Crocker et al., 2010; Fryer et al., 2004). Additionally, CD can often be confused with behaviors stemming from traumatic experiences, another common characteristic among children in RTCs. Children who have experienced trauma are more likely to display maladaptive or difficult behaviors such as aggression, which is sometimes perceived as defiance rather than as a trauma reaction.

In sum, CD and ODD are both associated with aggression and aggressive behavior is one of the most common underlying reasons children are admitted to RTCs. Additionally, children who are male are more likely to aggress towards others and children who are female are more likely to aggress towards themselves (Fryer et al., 2004). Since the majority of children in RTCs are victims of abuse and/or neglect, this places them at an even higher risk for exhibiting aggression since abuse is a well-established risk factor for future aggressive behavior (Connor, Steingard, et al., 2004; Ebesutani et al., 2014). Children who experience violence in the home and whose parents or caregivers struggle with substance abuse are also likely to exhibit aggression (Connor, Steingard, et al., 2004). In sum, aggressive behavioral tendencies among children in RTCs is a common characteristic and an integral barrier contributing to the difficulty these children have in functioning in an out-of-home setting.

**Child Maltreatment and Trauma**

Another common characteristic observed among children in RTCs includes a history of maltreatment and trauma. Children who were exposed to maltreatment and/or traumatic experiences comprise a large portion of the child RTC population (Zelechoski et al., 2013). Prevalence of child maltreatment and trauma also proves to be a pervasive social problem and a sizeable contributor to mental health difficulties (U.S. Department of Health and Human
Child maltreatment includes any type of abuse or neglect that a child experiences and accounts for a large portion of the traumas that young children experience, with neglect of a child being the most common, followed by physical abuse (De Bellis, 2005; Osofsky, 2011; U.S. Department of HHS, 2020). United States federal law defines child abuse and neglect as “any recent act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm” to an individual under the age of 18 (U.S. Department of HHS, 2020). Types of child maltreatment include sexual abuse, physical abuse, emotional/psychological abuse, and neglect (American Psychiatric Association, 2013; Felitti et al., 1998; Thomas, 2003).

Unfortunately, child abuse occurs more frequently than one might expect. In the United States in 2020, there were 618,000 (8.4 per 1,000 children) victims of child abuse and neglect. Younger children are the most vulnerable to maltreatment as more than one-quarter (28.6%) of the victims were children ages birth to 2-years-old. Moreover, there was a 2020 U.S. national estimate that 1,750 children died from abuse and neglect (2.38 per 100,000). Most of the fatalities included children younger than 1-year-old (46.4%) at a death rate of 23.03 per 100,000. Boys have a higher child fatality rate at 2.99 per 100,000 when compared with the fatality rate of girls at 2.05 per 100,000. African American children have the highest fatality rate at 5.90 per 100,000 when compared to the fatality rate of white children (1.90 per 100,000) and Hispanic children (1.65 per 100,000; U.S. Department of HHS, 2020). In sum, child abuse, maltreatment, and neglect occur too often and proves to be a pervasive social problem greatly impacting our society.
Traumatic events may also include experiences such as a natural disaster, loss of a caregiver, domestic violence, military deployment of a parent, among others (Osofsky, 2011). Moreover, two thirds of children experience a traumatic event by age 16 (2008 Presidential Task Force on PTSD and Trauma in Children and Adolescents, 2011). An increase in the number and duration of traumatic experiences, especially during critical developmental periods, places a child at higher risk for developing a psychological and/or physiological disorder. Children also tend to feel responsible for their traumatic experiences and have limited capability to comprehend and appropriately internalize the event(s) when compared to adults (Osofsky, 2011).

Despite the high prevalence of childhood trauma, people are still generally unaware of the profound impact that traumatic experiences have on young children and how variably a child’s response to trauma occurs (Osofsky, 2011). For example, a child may not show immediate changes in behavior or emotions after experiencing a traumatic event (Osofsky, 2011), making it difficult for adults and caregivers to detect any psychological effects that the trauma inflicted. Early trauma exposure also affects a child’s brain development which ultimately impacts their developmental trajectory (Osofsky, 2011). For example, a child who experiences abuse at a young age is at a four to five times greater risk of experiencing a developmental disorder including behavioral and/or mental health difficulties (Leslie et al., 2005). Trauma exposure early in life also alters physiological responses to stress and causes a child to be in an unhealthy and prolonged state of arousal (Osofsky, 2011). When a child experiences prolonged stress at a critical developmental stage, their brain structure may change (De Bellis et al., 1999) and their amygdala becomes hyperactive (Hughes, Baylin, & Siegel, 2012). Despite an established negative impact that early childhood trauma has on physiological and psychological...
development, the plasticity of young brains also allows children to derive significant benefit from trauma informed treatment (Osofsky, 2011).

Trauma informed treatment/care (TIC) is particularly important when treating children and adolescents in RTCs as most of the population has experienced at least one traumatic event. Not only does TIC increase the likelihood that treatment will be completed by the child and family (Ghafoori et al., 2019), but it proves to be more effective in targeting emotional dysregulation (Keeshin et al., 2021), a common symptom observed among children in residential treatment settings and among children who experienced trauma. Darnell et al. (2019) also reports that as the number of traumatic experiences increase, there is an increased likelihood that the adolescent will experience externalizing symptoms and PTSD symptoms. Thus, TIC is particularly relevant to RTC youth populations due to the high rates of children with a history of trauma exposure and externalizing disorders (e.g., aggression, ODD, substance use, etc.).

Exposure to chronic and/or complex trauma is also associated with more severe implications for child development, especially if the trauma is experienced within a child’s caregiving environment and at a younger age (Bremner, 2003; Herman, 1992; Osofsky, 2011; van der Kolk, 2005). Frightening and overwhelming caregiver behavior is also believed to be the most impactful traumatic experience there is (Gunnar & Quevedo, 2007). The theory behind these implications considers normal coping when a child is confronted with fear (Osofsky, 2011). Typically, a child will cling to a caregiver when exposed to a scary or stressful event, however, if a child’s source of stress involves their caregiver, the child is less able to process the trauma and is likely to feel persistent helplessness and fear (Osofsky, 2011). Chronicity and source of a child’s trauma is an important consideration because approximately 80.0% of the time, child abuse involves a child’s own caregiver (van der Kolk, 2005). Experiencing trauma at the hands
of a child’s own caregiver also increases the child’s likelihood of chronic trauma exposure due to the child’s increased activity of their stress response system, reduced functioning of their prefrontal cortex, and subsequent heightened sensitivity to stress (Siegel, 2012; Hughes, Baylin, & Siegel, 2012). Finally, prolonged exposure to stress is known to adversely impact brain development, and a child’s inability to rely on caretakers is associated with maladaptive change associated with the function of hormone systems (Hughes & Baylin, 2012; Kaufman et al., 1997; Osofsky, 2011).

Due to the difficulties that children who experience maltreatment and trauma face, many may require out-of-home care where rates of child abuse and neglect histories are especially high. For example, 38.0% of children in CPS custody that are enrolled in RTCs experienced child sexual abuse with all sexual abuse cases co-occurring with at least one other type of abuse; and 75.0% of sexual abuse cases co-occurring with all forms of abuse including physical abuse, emotional abuse, and neglect (Baker et al., 2006; Milne & Collin-Vézina, 2014). Overall, most children in RTCs have experienced complex, chronic, and multiple forms of maltreatment and trauma including physical abuse, sexual abuse, witness to domestic violence, and/or loss of a caregiver (Finkelhor et al., 2007; Weine et al., 1997). As a child’s number of experienced traumas increase, rates of functional impairment increase, which includes more negative affect, more aggression, and a higher risk for developing psychopathology (Briggs et al., 2012; Ebesutani et al., 2014). Development of psychopathology in childhood increases risk for requiring out-of-home care, such as residential treatment, and is typically manifest among children with behavioral and emotional disturbance.

Another important consideration is that removing a child from an abusive situation (i.e., placing them in an RTC) is typically not sufficient to help them achieve functional
resocialization (Zimmerman et al., 1997). Moreover, removing a child from the care of an abusive caregiver can be traumatic in itself (Little et al., 2005) because the abusive caregiver is often the only caregiver that the child has known and with whom the child has likely formed an attachment (Osofsky, 2011). Typically, the abusive caregiver has also been traumatized themselves, which decreases their ability to be emotionally present for their child (Hughes & Baylin, 2012; Osofsky, 2011). Recent estimates state that more than four-fifths (83.2%) of child abuse perpetrators were between the ages of 18 and 44, and more than one-half (52.0%) were women (U.S. Department of HHS, 2020).

Some major risk factors for child abuse and neglect includes caregiver (most commonly a parent) domestic violence, and alcohol and drug abuse (U.S. Department of HHS, 2020). The prevalence of caregiver substance abuse (CSA) among child residential populations should be acknowledged as an important component often associated with experiences of childhood maltreatment and trauma. Among children in RTCs, approximately 65.0% have parents or primary caregivers who have abused alcohol (Connor, Doerfler, et al., 2004). More specifically, CSA is associated with a high risk for serious emotional disturbances among children (Kerker & Dore, 2006) and places children at a higher risk for experiencing violence in the home (Yaghoubi-Doust, 2013). CSA also increases a child’s risk for experiencing maltreatment and other harmful experiences such as a lower likelihood of reunification with their caregiver(s) and more time in foster care (Becci et al., 2015). Specifically, 52.0% of children in CPS custody have experienced both CSA and serious emotional disturbance (Becci et al., 2015).

Caregivers struggling with substance abuse (SA) are also believed to provide poorer quality caregiving as evidenced by limited supervision and monitoring of their children, inconsistent disciplinary practices, and less time for caregiving due to preoccupation with
obtaining and using substances (Francis, 2011; Pilowsky et al., 2001). Caregivers who experience SA are also more likely to be impacted by other factors associated with poor caregiving such as low socioeconomic status, personal trauma exposure, mental illness, and limited social support when compared to caregivers who do not struggle with SA (Becci et al., 2015; Lam et al., 2004). Children exposed to CSA are also more likely to adopt maladaptive behaviors such as substance use, risky sexual behaviors, and other risk taking behavior when compared with children who did not experience CSA, all of which place them at increased risk for being traumatized themselves (Francis, 2011).

Overall, exposure to maltreatment and trauma impacts individuals at all stages of life and is especially impactful when experienced at a young age. Examining the effects of trauma has been popular throughout the literature which has highlighted associations between childhood trauma exposure and adverse health conditions as adults, which eventually lead to early death (i.e., ACES; Felitti et al., 1998). Moreover, approximately 80.0% of individuals who experienced maltreatment and trauma during childhood will fail to meet criteria for healthy psychosocial functioning as adults (McGloin & Widom, 2001).

Child RTCs play an important role in combating the adverse effects associated with childhood maltreatment and trauma as the impact of childhood trauma is not necessarily irreversible (Osofsky, 2011). There are efficacious interventions that help ameliorate symptoms associated with childhood maltreatment and trauma such as the formation of a close relationship with a trustworthy and safe adult (Lynch & Cicchetti, 1998; Osofsky, 2011). Strengthening a child’s connection with their primary caregiver can also attenuate physiological and psychological effects of childhood trauma (Osofsky, 2011). Common treatment goals for children in RTCs involve helping the child who has experienced trauma form healthy
attachments with safe adults. Family therapy is also a common intervention used in RTCs for children. Therefore, continued research with children who have experienced trauma and who also require out-of-home care is very important because implementing effective treatments can help offset the deleterious effects associated with childhood trauma. One goal of the study was to examine the transitional experience out of RTCs as an important component of residential treatment. More specifically, the long-term goal of examining the transitional experience is to improve care (i.e., residential treatment) for children who experienced maltreatment and/or trauma.

**Residential Treatment Outcomes**

The literature examining RTC outcomes for children has historically yielded unclear conclusions (Bates et al., 1997) and recent studies have found that children typically make treatment gains initially, but then regress post-discharge (Blader, 2004; Cafferty & Leichtman, 2001; Friedman et al., 2016; Leichtman & Leichtman, 2001; Patel et al., 2018; Whittaker et al., 1988). One study concluded that RTCs can effectively serve children with high needs within a six-month period (Lyons et al., 2009) as long as intensive community supports are available post-discharge (Preyde et al., 2018). However, treatment effectiveness is compromised if services post-discharge are either not available or not utilized because preparing a child to function in the community proves difficult without appropriate supports. Other variables impacting treatment effectiveness include RTC LOS (Budde et al., 2004; Wickizer & Lessler, 1998; Lakin et al., 2007; Vogelsang, 2018; Vogelsang et al., 2019), the context of the child’s discharge, and child psychopathology (Hussey & Guo, 2005). In general, children who are “stepped-down” to a lower level of care are more likely to get needs met (Lyons et al., 2009).
One study included young adults formerly enrolled in an RTC and aimed to explore their perspectives on their life since RTC discharge (Gallagher & Green, 2012). Findings stated that participants generally reported having “good” relationships with staff members at the RTC, enjoyed their leisure time, appreciated therapy focused on describing their life story, and were happy to have ongoing contact post discharge with staff who had cared for them. Others described appreciation for the school they attended, the friendships they formed, and the preparation they received prior to transitioning out of the RTC. Other conclusions were that RTCs can offer quality care to children and that there is opportunity to help children form meaningful, safe relationships with staff members which may positively impact them long-term (Gallagher & Green, 2012). Moreover, there is sufficient evidence to suggest that residential treatment programs yield a significant reduction in clinical symptoms, yet much less is known about the child’s long-term functioning (Little et al., 2005).

One indicator of treatment outcome includes rate of readmission, which is strongly influenced by the child’s LOS in treatment. Research demonstrates that many individuals admitted to IPFs and/or RTCs eventually return to out-of-home treatment at some point post-discharge. Among children admitted to IPFs, one study found that 81.0% of the children were readmitted within ninety days post discharge (Blader, 2004). Other studies found that among children discharged from an RTC, 32.0% returned to treatment within the first year following discharge, 53.0% returned within two years following discharge, 59.0% returned within three years following discharge (Asarnow et al., 1996), and 44.8% of adolescents returned to treatment at some point in their life (Pedersen & Aarkrog, 2001).

Furthermore, individuals who receive psychiatric services as a child are 50 times more likely than the general population to be readmitted to a mental health institution (Pedersen &
Aarkrog, 2001) with approximately 40.0% re-hospitalized within one year post discharge (McLaughlin, 2003). Moreover, children who display more severe impairment in functioning at the time of discharge are more likely to be readmitted (Lakin et al., 2007). Children who experience more severe conduct difficulties and externalizing behaviors are also more likely to be readmitted to an IPF (Fite et al., 2008; Gutterman, 1998). Thus, a large percentage of children admitted to an IPF and/or an RTC are eventually readmitted and are likely to struggle with mental health difficulties long-term. Baker et al. (2003) found that children who were transferred from an RTC to an IPF demonstrated more serious problems over time when compared with children who did not require transfer. More specifically, these children were more likely to run away, act violently, engage in sexualized behavior, attempt suicide, and destroy property (Baker et al., 2003). In general, a child’s risk for readmission is very small when a child has experienced no new admissions eight years following initial discharge (Pedersen & Aarkrog, 2001).

The literature also demonstrates variable average time between initial discharge from an RTC or an IPF and readmission, with estimates ranging from 35 days (Leon et al., 2016) to 32 months (Pedersen & Aarkrog, 2001). Moreover, the type and number of psychiatric diagnoses that the patient receives and whether they receive services post-discharge greatly impacts their risk for readmission (Pavkov et al., 1997; Pedersen & Aarkrog, 2001; Yampolskaya et al., 2013). Patients diagnosed with schizophrenia or other psychotic disorders are more likely to be readmitted than patients diagnosed with other disorders (Hamilton et al., 2015; Pavkov et al., 1997; Pedersen & Aarkrog, 2001). Patients with multiple diagnoses are also at a higher risk for readmission than patients with one or zero diagnoses (Yampolskaya et al., 2013). One study found that adults discharged from a substance abuse RTC were less likely to be readmitted and more likely to enroll in post-discharge mental health care as the patient’s LOS in treatment
increased (Moos et al., 1995). Participation in community mental health treatment following discharge from an RTC is also associated with better treatment outcomes (Curry, 1991; Lyons et al., 2009) such as a lower likelihood for readmission, especially among child and adolescent populations (Pavkov et al., 1997; Yampolskaya et al., 2013).

Additionally, patients with a high degree of symptom severity and functional impairment (excluding suicidality) are at a higher risk for IPF readmission when compared to patients with less symptom severity (Lyons et al., 1997). Children with a diagnosis of CD and/or ODD experience a higher likelihood of readmission to an IPF (Blader, 2004; Chung et al., 2008; Foster, 1999). Lastly, children and adolescents who are discharged to a low socioeconomic status community are more likely to be readmitted to an IPF when compared to individuals who are discharged to a higher socioeconomic status community (Pavkov et al., 1997).

A child’s LOS in treatment over the course of one admission at an IPF and/or RTC is also known to be a predictive variable for future readmission (Budde et al., 2004; Lakin et al., 2007). To date, the literature clearly suggests that as a child’s LOS at an RTC declines, their risk for readmission increases (Budde et al., 2004; Lakin et al., 2007; Wickizer & Lessler, 1998). Varying length of treatment in an RTC is often due to uncontrolled factors such as funding and discharge options (Lakin et al., 2007). Moreover, research examining variables associated with LOS is sparse in the literature, however, some evidence suggests that LOS should be dependent on available community resources upon discharge (Baker et al., 2005).

Funding difficulties are one explanation as to why children experience a short LOS at an RTC and is believed to have a negative impact on treatment outcomes among this population. More specifically, pressure from managed care companies to discharge children from RTCs is believed to increase rates of discharge before the child is clinically ready (Lakin et al., 2007;
Leichtman & Leichtman, 2001), likely because the child has less time to complete their treatment goals. In general, children and adolescents enrolled in RTCs who complete their treatment program will be more likely to experience positive outcomes post-discharge (Frankfort-Howard & Romm, 2002; Hair, 2005). Other sources report that approximately 45.0-51.0% of RTC discharges are unplanned, which indicates that their clinical readiness to discharge is disregarded as a result of other factors impacting the need for the youth to transition (Scholte & van der Ploeg, 2000; Sunseri, 2001). In general, unplanned discharges are associated with a worsened outcome trajectory for the youth (Preyde et al., 2019) and longer LOS in out-of-home treatment is associated with a lower likelihood for readmission at a one year follow-up (Moos et al., 1995).

In general, the literature has identified LOS as a well-established factor impacting RTC readmission rates (Vogelsang et al., 2019). Moreover, the literature also indicates that funding difficulties are a common problem experienced by children in RTCs and that many children are discharged solely because of funding difficulties (Lakin et al., 2007; Vogelsang, 2018). Thus, shorter LOS is sometimes experienced due to reasons out of the control of the child and their treatment team.

**Transitional Experience**

The primary goal of residential treatment is to stabilize a child’s behavior and treat underlying behavioral, mental health, or substance abuse issues which were causing significant distress and impairment. Therefore, transitioning the child to a sustainable long-term environment post-discharge in which they can maintain treatment gains is an important goal (Tatsiopoulou et al., 2020), however, this is often not the focus of residential staff members who are trained to address the therapeutic milieu (Hess et al., 2012; Leichtman & Leichtman, 2001). Moreover, little is actually known about how youth handle life after residential treatment as RTC
staff members are typically unable to monitor youth post discharge (Preyde et al., 2019). Many posit that residential treatment is most effectively conceptualized as one piece of the entire treatment process, which includes aftercare services (Curry, 2004; Preyde, 2018, 2019). Unfortunately, despite noticeable improvements made while in treatment (Preyde et al., 2011), gains are often lost after the child leaves the RTC (Blader, 2004; Leichtman & Leichtman, 2001; Patel et al., 2018; Whittaker et al., 1988) as evidenced by high rates of readmission to out-of-home placements (Asarnow et al., 1996). Other aspects impacting a patient’s ability to leave an RTC includes their degree of social support upon discharge (Hair, 2005; Frensch & Cameron, 2002) and opportunities to engage in aftercare services such as school based intervention programs and community mental healthcare (Hamilton et al., 2015; Pavkov et al., 1997; Yampolskaya et al., 2013).

One recent study explored post RTC discharge perspectives of youth, caregivers, and a mental health provider involved with the child one year post RTC discharge (Preyde et al., 2019). Findings indicated that most of the youth and their caregivers included in this study reported improvement in their relationship within the first month, with some reporting maintenance of their relationship over time; however, deterioration in the parent-child relationship over time appears to be a trend. Primary difficulties experienced within the first year included managing ongoing mental health symptoms (i.e., aggressive behaviors, depression, self-harming or suicidal ideation, and addictive behaviors), managing interpersonal relationships, navigating the negative behaviors of peers, school difficulties, and developing life skills and independence. Youth’s mental health difficulties appeared to be exacerbating their difficulty managing other important areas of their life. Another important finding was that parents of the youth reported their own personal history of adversity (e.g., financial, relational, mental illness), trauma (e.g., sexual
assault, abandonment), and addiction (Preyde et al., 2019). Results from this study support the literature more broadly which suggests that it should be expected that youth transitioning out of RTCs need continuity of care and ongoing supports including family interventions and attention to the goodness-of-fit between the youth and their discharge placement (Brown et al., 2011; Preyde et al., 2019; Sunseri, 2004; Trout et al., 2010).

To date, the literature cites four common overarching experiences and factors associated with the RTC transitional process among children in RTCs. These topics include perspectives from children who are also involved in the foster care system, caregiver perceptions about their child’s transitional experience, transitions out of residential substance abuse treatment, and clinical readiness to discharge. First, children who are involved in the foster care system are enrolled in RTCs at higher rates than children who are not in foster care (Bates et al., 1997). Literature has explored the transitional experience out of residential treatment either back into a foster family, into the adult world, and/or to another placement. One study examined foster youth’s perception of transitioning from an RTC to a therapeutic foster family, and identified themes such as youth fears about placement disruption, hopes to establish family ties, and the need for preemptive problem solving, and expectation setting (Narendorf et al., 2012).

Second, caregivers frequently express concern and report feelings of anxiety about their child returning home after completing residential treatment (Leichtman & Leichtman, 2001; Patel et al., 2018) which include fears associated with the possibility for behavioral regression (Buchbinder & Bareqet-Moshe, 2011). Parents also express experiencing guilt associated with the initial removal of their child from the home combined with feeling pressure to have them return home from the RTC (Buchbinder & Bareqet-Moshe, 2011). Additionally, caregivers tend to report that their child’s “previous behaviors” and problems typically resurface after
approximately two weeks post-discharge (Patel et al., 2018, p. 2). More specifically, caregivers often perceive the transition process as occurring throughout the entirety of treatment (Hess et al., 2012) and family involvement in treatment is a known factor impacting success post-discharge (Frensch & Cameron, 2002; Hair, 2005).

Another study found that caregivers expressed experiencing difficulties such as fear about whether their child’s change in behavior was authentic, and personal insecurities about their response to their child, all of which are believed to impact transitional success (Hess et al., 2012). Other studies found that caregiver and mental health care professionals’ perceptions about a child’s post-RTC discharge include child difficulty re-establishing peer relationships, child difficulty managing emotional experiences, and a lack of professional and community support offered to the family (Clemens et al., 2010; Patel et al., 2018). Treatment foster parents also report that their foster youth’s transition typically entails getting to know their foster child, getting settled, and readjusting their family life (Castellanos-Brown & Lee, 2010). In sum, the literature recommends that more support be provided to youth and foster parents before, during, and after the youth moves into their care from an RTC.

Improving access to such supports and providing foster parents with adequate information about their foster child would help youth learn how family living may be different and subsequently ease their transition back into the community. Moreover, the literature suggests that “stepping-down” youth too soon could be detrimental for treatment maintenance (Castellanos-Brown & Lee, 2010). Stepping-down one’s level of care is the process of transitioning an individual to increasingly lower levels of care while providing appropriate support and intervention throughout the process, for example via home visits.
Third, studies conducted with individuals who were enrolled in substance abuse RTCs also support the broader literature regarding RTC transitional experiences. For example, one study concluded that adolescents who participated in a Focused Continued Care program post substance abuse RTC discharge reported higher rates of sobriety (Cacciola et al., 2008). Another study corroborates such findings and concludes that young adults transitioning from residential substance abuse treatment experienced distress during transitional periods, however, distress was minimized by a programmatic step-down process (Duroy et al., 2003). Other studies conducted among residential substance abuse samples concluded that individuals fare better when appropriate support networks are provided post-discharge which may include access to housing, discharge planning, aftercare services, and funding assistance (Cafferty & Leichtman, 2001; Manuel et al., 2017).

Finally, clinical readiness to transition out of an RTC is another important consideration impacting the transitional process and has not been well studied to date (Vogelsang et al., 2019; Tatsiopoulou et al., 2020). The literature generally defines clinical readiness in several ways including the ability of the patient and their family to leave the facility (Steele & Sterling, 1992) and their attitudes about maintaining changes post discharge (Gamble et al., 2011). External factors should be considered when planning a child’s transition out of an RTC due to the vast literature indicating that aftercare services and family involvement are important factors in maintaining long-term success.

Identified indicators of clinical readiness to discharge includes whether the child has achieved certain milestones such as successful emotional and behavioral change witnessed by and agreed upon by RTC staff (Hair, 2005). Other indicators include the child’s completion of the residential treatment program, and the child’s planned discharge to a less restrictive
placement (Hair, 2005). The child’s level of impairment in functioning at the time of their discharge is another important variable (Lakin et al., 2007). In general, children who experience a shorter LOS in an RTC are more likely to be discharged before they are clinically ready, thus, increasing their risk for readmission (Lakin et al., 2007). Therefore, future studies examining the transitional process would benefit from considering how clinical readiness to discharge may be impacting the child’s experience leaving the RTC. In sum, the way a child transitions out of treatment and how this process is structured is believed to have an impact on the individual’s experience and treatment outcomes (Narendorf et al., 2012; Tatsiopoulou et al., 2020).

**Adult Perspectives on Childhood Experiences**

The literature is clear about the lack of research describing child RTC experiences (Chama & Ramirez, 2014), nonetheless from an adult perspective. Obtaining data from adults who lived in an RTC as a child and who experienced transitioning to another placement is unique and would contribute to the literature in a meaningful way. This study was designed to obtain stories from adults who lived in an RTC(s) as a child. There are multiple reasons for including adults rather than children. First, adults demonstrate more complex cognitive functioning and a greater ability to describe their experiences than children or adolescents. Typically, children and adolescents do not have the vocabulary and necessary language abilities to describe their experiences in the same degree of detail as adults (assuming no cognitive disability). Second, there is little research conducted on the topic of interest that includes adult participants reflecting on their childhood experiences. Third, children are considered a vulnerable population and are difficult to research due to various ethical and accessibility factors. Including adult participants allowed for the participants to consent and assent without the need to involve a parent or
guardian. Thus, since the goal of the study was to obtain participant stories associated with their experience transitioning out of an RTC, literature utilizing similar methods is briefly reviewed.

Literature pertaining to all aspects of this study proved minimal, however, two relevant studies will be discussed. One study utilizing phenomenological methods included participants between the ages of 18 and 30 who described their experience transitioning out of a group home as a child after they reintegrated into a community setting (Famalette Boylan, 2016). Participants were asked to reflect on aspects of the group home programming which they believe helped them achieve a successful transition. All participants were considered to have achieved a successful transition which was determined by the following criteria: the participant meeting their treatment goals and subsequently being deemed ready to discharge by the group home staff. Observed patterns within the data indicated that participants felt as though they received support from group home staff members, that they received adequate assistance in learning money management, and that they received effective job training. Other findings indicated that participants knew about their discharge ahead of time, received preparation for life after transition, procured housing prior to discharge, and received continued social support post-discharge. Important conclusions of the study include observation that the skills participants learned while enrolled in residential treatment did not seem to translate into their life in the community. Thus, simply teaching skills to children while they are in treatment is not sufficient in helping participants function well long-term. Moreover, participants expressed experiencing better post-discharge adjustment when able to stay in contact with the RTC staff that cared for them.

Another study aimed to describe the experiences of participants who formerly attended a faith-based group home. Thirty adult male participants reported on their experiences as a child in
the group home (Chama & Ramirez, 2014). Open and axial coding was utilized to formulate themes and patterns reflective of the data. Participants identified the following topics: program atmosphere, staff, punishment practices, counseling, spiritual development, and issues associated with re-entry. Participants reported feeling as though the group home fostered a “prison-like” atmosphere and that there were obvious discrepancies between written expectations and what was implemented. Other participants recounted experiences of abuse while residing in the group home such as verbal put-downs and staff withholding food as punishment. It was also reported that staff would humiliate the residents and many also described participating in unhelpful, low frequency counseling. Other perspectives included there being coercive religious practices and a lack of preparation for life after discharge (Chama & Ramirez, 2014).

Summary Statement

As demonstrated, there are very different experiences, perspectives, functions, and outcomes reported as they pertain to the lives of children in RTCs. Moreover, there is scant literature on the topic, especially from the perspective of adults who were enrolled in RTCs as children. This study contributes to the literature by providing a unique perspective on an aspect of residential treatment for children that has been under-studied thus far: an adult account of their experience transitioning out of an RTC as a child. Researchers purposely selected participants for this study with the intention to obtain their stories associated with transitioning out of an RTC as a child. All enrolled participants attended an RTC in the United States as a child for at least 6 consecutive months. Use of adult participants enriched the data obtained because the participants experienced a longer time removed from residential treatment. The hope was that adults would offer a more mature, fresh description of their experience than a child may.
Purpose of the Study

The purpose of the study was to understand how adults who transitioned out of an RTC as a child recounted their experiences before, during, and after their transition out of the RTC. Narrative research methods were chosen for the purpose of garnering a wholistic perspective about the participants’ context associated with transitioning out of an RTC.

Research Questions

I aimed to answer the following three research questions via use of the study.

1. How do adults who transitioned out of an RTC as a child recount their experiences before, during, and after their transition?
2. Which lived experiences do these adults perceive to have been the most impactful in their life trajectory?
3. In what ways have these adults integrated their experience leaving an RTC as a child into the broader context of their life story?

Significance of the Study

Advancing knowledge about this experience will inform future inquiry regarding ways to improve the transition out of residential treatment with the intent to ultimately improve treatment outcomes for this population. This study is important due to the scant research conducted among child residential populations to date, with very few qualitative studies illuminating first-person perspective(s) of participants (Chama & Ramirez, 2014). The study is also unique because participants provided an adult account of their childhood experiences during a critical transitional period. Including participants who had time to live life post residential treatment and to experience some degree of adulthood is unique and provided a rich description of how their life as a child in residential treatment impacted them. Results also inform ideas about residential
treatment outcomes as they relate to this crucial transitional period and how this period impacts individuals into adulthood.

**Methods**

This section is prefaced by the perspective that “methods are through and through social and communal” (Gee, 2011, p. 11). All disciplines of research utilize strategies that are continually crafted to answer identified questions about the world and which require social processes to create methods and make meaning (Gee, 2011). Moreover, research strategies and theory appear to be inseparable and underlie every research process (Gee, 2011; Kim, 2016). Thus, researcher focus throughout this study was grounded in theory which necessarily drove methodological choices.

Narrative methods address the identified gap in the literature because they allow for the topic to be explored in-depth, through stories. As part of this modality, participants were allowed opportunity to recount how leaving an RTC as a child impacted their life. Moreover, the literature does not narrowly define what an RTC is, which makes justifying other types of qualitative inquiry difficult. For example, phenomenology requires identification of a well-defined phenomenon (Moustakas, 1994). Although a child’s transition out of RTCs is a phenomenon, it is not yet considered a well-defined phenomenon due to a lack of a refined definition of an RTC.

Narrative inquiry is different from other qualitative research methods because rather than utilizing a “category-centered” approach to data analysis often seen in phenomenology or grounded theory research, narrative data analysis is “case-centered” in which the focus is directed to the content and the way experiences are storied by participants (Reissman, 2008, p. 12/13).
Methods were emergent and co-constructive in nature which allowed me to refine questions and to change course throughout the study, as appropriate (Creswell & Poth, 2018). Additionally, the definition of a “story” is a “detailed organization of narrative events arranged in a (story) structure based on time although the events are not necessarily in chronological order” (Kim, 2016, p. 8). The following discussion uses the terms “story” and “narrative” interchangeably for ease of reading as “narratives constitute stories, and stories rely on narratives” (Kim, 2016, p. 9).

**Interpretive Framework**

It is important to first proclaim the frame of reference in which the study was designed and subsequently how data was collected and interpreted. The interpretive framework is the broadest component of theory in which the study is framed, often referred to as the “macro-level” (Kim, 2016, p. 33). The methodology utilized (in this case, narrative) begins to further narrow the study and subsequently operates at the “meso-level” (Kim, 2016, p. 33). Therefore, the study is most broadly discussed through the lens of a Social Constructivism framework, which emphasizes the participant’s experiences and associated meaning(s) in the world they live and work (Creswell & Poth, 2018).

A Social Constructivism framework allows for reality to be co-constructed through collaboration between the researcher and the participants for the purpose of gaining a deeper understanding of the individual’s experiences, and world (Creswell & Poth, 2018; Moustakas, 1994). Reliance on the participants’ perspective(s) is necessary within this framework to identify the emergence of theory and/or patterns of meaning from participant testimony, thus, semi-structured and open-ended interview protocols allow for careful listening (Creswell & Poth, 2018; Kim, 2016). Additionally, the premise of qualitative work is not to impose a structure for
which participants must assign meaning, but rather, allow openness for which meaning can be
constructed from the ground-up (Dukes, 1984; Kim, 2016).

Philosophical Assumptions

Philosophy is also a central component in research and cannot be overlooked when
conducting empirical research with human subjects (Kim, 2016; Wertz et al., 2011). Qualitative
research methods stem from the principles pioneered by historic scholars including Gordon
Allport, Sigmund Freud, Jean Piaget, Erik Erikson, Jerome Bruner, Michel Foucault, Edmund
Husserl, and Barney Glaser, among many others (Kim, 2016; Wertz et al., 2011; Reissman,
2008). Narrative inquiry is one of five qualitative approaches born from these scholars (Wertz et
al., 2011) and employs methods such as restorying, thematic analysis, and identification of
epiphanies and major events (Creswell & Poth, 2018; Czarniawska, 2004; Denzin, 2001; Huber
& Whelan, 1999; Polkinghorne, 1995). Narrative research also shares philosophical principles
with phenomenology as the two approaches aim to facilitate discovery of meaning of a lived
experience (Moustakas, 1994; Wertz et al., 2011). Narrative inquiry is interdisciplinary and
utilizes “interpretive lenses with theoretically, philosophically, diverse approaches and methods,
all revolving around the narrative and stories of research participants” (Kim, 2016, p.6).
Narrative research methods are utilized in psychology, law, education, medicine, anthropology,
sociology, history, business, and philosophy, among others (Kim, 2016).

Primary underlying assumptions of narrative research are that “it begins with the
experiences as expressed in lived and told stories of individuals” (Creswell & Poth, 2018, p. 67).
Narrative research is also collaborative in nature and meaning is expected to emerge from co-
construction of stories between the researcher and the participant(s). It is also a unique and
diverse approach to research due to the emphasis on chronology and sequence of events detailed
by stories containing a beginning, middle, and an end (Cortazzi, 1993). It was the chosen modality for this study because I was equipped to allow participants opportunity to recount experiences across their lifetime and to do so in a chronological and in-depth manner. Narrative scholars aim to create meaning from the participant’s single case rather than from “themes and categories across cases” (Reissman, 2008, p. 53). For example, narrative researchers may focus on the meanings that emerge from the way a story is communicated (i.e., which events are included and when) rather than the meanings that emerge from patterned snippets of data observed across multiple participants (Reissman, 2008). Narrative inquiry is also described as “cross-disciplinary, a many layered expressions of human thought and imagination” (Reissman, 2008, p. 13).

Obtaining narratives also allows participants to describe their stories in a way that best represents how they perceive and make sense of an experience. The construction of stories is believed to help humans make sense of their past, present, and future selves in various social contexts (Kim, 2016; McAdams, 2008; Reissman, 2008). Narrative identity is one component of narrative construction and refers to an individual’s “internalized, evolving, and integrated story of the self” (McAdams, 2008, p. 242). In general, narratives are presented in the form of “a spoken or written text giving an account of an event/action or series of events/actions, chronologically connected” (Czarniawska, 2004, p. 17).

Narrative inquiry is relevant to the human experience because story making exists in every culture and serves as a method for making meaning starting in early childhood (McAdams, 2008; Reissman, 2008; Schacter, 1996; Wertz et al., 2011). Moreover, the way individuals tell stories is largely influenced by social context (McAdams, 2008; Reissman, 2008). For example, the stories a person tells may be influenced by the way they wish to present themself-and/or may
depend on the demands of the audience (Pasupathi & Rich, 2005). Specifically, most people prefer some sort of reaction from the listener (Reissman, 2008; Thorne & McLean, 2003) with adolescents and young adults tending to tell stories in a more dramatic and entertaining manner than older adults (McLean & Thorne, 2006).

There are also individual benefits to personal narratives because life stories are “always about both the reconstructed past and the imagined future” (McAdams, 2008, p. 244) and they allow for people to simultaneously constitute and make sense of the past (Reissman, 2008). The process of telling life stories allow people to integrate various life events in a structure that helps them consolidate dissonant self-conceptualizations (McAdams, 1985; Reissman, 2008). Narrative identity allows people to construct and reconcile discrepant personal characteristics with their current and/or ideal self (McAdams, 1985) while connecting their biography with broader society (Reissman, 2008).

Some may question the reliability of memory pertaining to personal narratives. Although autobiographical memory is known to be unstable, the main aspects of memories are typically consistent with only the details being subject to change over time (Schacter, 1996). Moreover, the data was interpreted through a social constructivist lens which focuses on human construction of meaning and understanding of their work. Thus, narrative truth is often confused with historical truth as narrative truth pertains to the stories told by individuals whereas historical truth pertains to the facts of the past (Kim, 2016). One’s life story may change over time as the way they relate to their social world changes as a function of new life experiences being synthesized into their personal narrative (McAdams, 2008). Narrative inquiry is not concerned with historical facts but rather aims to describe experiences with the goal to co-construct meaning associated with the narratives (Wertz et al., 2011). Therefore, narrative data collection
aimed to address the posed questions about malleability of memory over time because the stories described by adults is of interest rather than the details and facts associated with an experience. The narratives and described events were constructed via use of memory, which is social constructivism.

Stories can be evaluated as “good” or “bad” from a psychological standpoint and within a particular context (MacIntyre, 1981; McAdams, 2008). For example, narrative psychotherapy utilizes client narratives to help them restory their life in a way that promotes healing and change (McAdams, 2008). Similarly, narrative research allows participants the opportunity to discuss events that they perceive are important and meaningful (Riessman, 2008). I collected data via participant stories which allowed for emergence of meaning.

Participants were asked to describe their experiences with inclusion of contextual details such as “physical, emotional, and social situations” (Creswell & Poth, 2018, p. 69). I strived to stay acutely attuned to context as the stories are intended to be situated and framed within the participant’s context (Czarniawska, 2004; Reissman, 2008). Although I asked the same questions to each participant (except for the participant who only completed two interviews), aspects of each interview (such as the order in which questions were asked) differed depending on the conversation and due to the focus on fostering story telling.

**Researcher Positionality**

Qualitative research is markedly different from quantitative research methods because the researcher is valued as the mechanism for which knowledge is discovered and brings forth excitement and genuine curiosity to the work (Moustakas, 1994). Researcher transparency about positionality and assumptions are imperative when conducting rigorous, sound, and ethical qualitative research (Saldaña, 2011). Fundamentally, humans are multicultural beings incapable
of completely separating themselves from personal biases and experiences (Creswell & Poth, 2018). Additionally, the person of the researcher underlies research pursuits by shaping the identified topics, questions, populations, methods, and data interpretations. Appropriately acknowledging the person and role of the researcher is important “in order to launch the study as far as possible free from prior experiences and professional studies—to be completely open, receptive, and naïve in listening to and hearing research participants describe their experience of the phenomenon being investigated” (Moustakas, 1994, pg. 22).

My initial goal in conducting research among this population was to improve treatment delivery and outcomes for children in residential treatment. I originally started working with children in RTCs because I have a passion for helping children heal from hardships such as mental health issues, maltreatment, trauma, substance use, and/or general family discord. Moreover, I have the belief that providing intervention in childhood can be one of the most impactful and meaningful experiences in a person’s life.

Since starting my work in direct contact with residential child populations approximately nine years ago, many questions arose. Throughout my graduate training, my understanding of the close relationship between clinical practice and research has evolved such that my clinical experiences have informed my research endeavors and vice versa. The fundamental question that has guided my research thus far is: Why do children keep coming back to residential treatment? As a result, my master’s thesis utilized quantitative methods and tested the degree to which certain variables predicted children at risk for readmitting to an RTC. Since then, I have continued to work in different residential and inpatient settings with children and adolescents and have continued to wonder what they experience and how that might impact treatment outcomes and their life trajectory. I have even cared for the same children in multiple settings as they
continued to be readmitted to RTCs and IPFs. Anecdotally, my experiences highlight a significant problem that is sorely lacking in research. My observations are also supported by the literature, thus highlighting the importance of continued work in this area.

In addition to pondering high rates of RTC readmission, I also wondered about what it would be like to be one of the children with whom I worked. I always imagined that when a child leaves a place that they learned to trust and where they may have developed one of their only safe relationships with an adult, the transition would be incredibly difficult. I also noticed that the children I cared for typically regressed in the weeks prior to their discharge as evidenced by increased anxiety, aggression, and tantrums. Moreover, I rarely received updates about how they were doing post-discharge. I believe that understanding the perspective of the individual(s) who had these experiences will help inform treatment and better direct interventions designed to improve experiences and outcomes. Understanding common experiences and how adults describe their childhood experiences would allow for further inquiry into understanding the nature of the transitional experience out of an RTC. In sum, I approach this research with a passion for the population and with the unique experience of working as a helper in RTCs and IPFs in various capacities including the following: observer, intern, direct care staff member, individual therapist, group therapist, psychological assessor, and researcher.

I am a proponent of out of home placement and residential treatment for children when it is needed. I also believe that an essential part of utilizing RTC placements is the ability of professionals to accurately answer the following questions: who is appropriate, when is placement appropriate, what type of placement is appropriate, for how long placement is appropriate, and why is RTC placement appropriate. I believe that RTCs are necessary for some children, and I believe that the experience can greatly alter someone’s life, for positive or
negative. Therefore, embarking on this research is important to me. I believe that effectively utilizing RTCs will increase positive treatment outcomes and decrease harm associated with RTC placements. I urge that readers bear in mind my bias and frame the data interpretation with my personhood in mind, as I cannot fully separate myself. I also describe below how integrity measures were used to ensure honesty and believability of the findings.

In addition to explaining my background related to the proposed topic, I also want to discuss my interest in qualitative research. I was initially drawn to qualitative inquiry after working with a former colleague in my graduate research lab who conducted a phenomenological dissertation study. After helping her with data transcription and coding, I was intrigued by the methods she used. Then, after taking a graduate level course with Dr. Craig McGill, I quickly realized the importance of theory and philosophical underpinnings in empirical research, both of which aligned well with my longstanding interest in philosophy: “theorizing becomes philosophizing, rendering all qualitative researchers philosophers” (Kim, 2016, p. 31).

Thus, I found myself truly wanting to learn more about how to conduct qualitative research, a topic intrinsically motivating for me to learn about and one that inspired a preliminary study described in Appendix C. While writing the narratives in this study, I found myself feeling genuinely excited about sharing the experiences of the participants. Moreover, although my formal training in philosophy is limited to an undergraduate minor, I would have completed a double major in psychology and philosophy had I not stumbled upon the discipline so late in my college career. Since learning more about qualitative research, I find that the methods fit with how I conceptualize knowledge and understanding. Therefore, shifting my conceptualization from a quantitative perspective to a qualitative perspective has felt both challenging and natural for me. I hope you find this dissertation to be high-quality. I also hope you find that this study
sheds light on the importance of conducting more research both with children in RTCs and via use of qualitative (specifically narrative) methods.

Participants

**Number of Participants**

The central premise of narrative research is to explore and describe participant stories in-depth, thus, the number of participants included in this study is consistent with narrative research which requires at least one participant (Creswell & Poth, 2018). Since there is no intention to generalize results, inclusion of few participants allows for exploration in significant depth. Whether enough data has been collected is based upon the appropriateness of the datum rather than on the number of participants included (O’Reilly & Parker, 2012). Data saturation was obtained which allowed for in-depth analysis addressing the research questions (Kim, 2016). There was a total of six participants included in the study. Four participants completed five one-hour interviews, one participant completed four one-hour interviews, and one participant completed two one-hour interviews.

**Recruitment**

Criterion sampling was used to purposely select participants (Creswell & Poth, 2018). Inclusion criteria included the following: participants were required to fluently speak English, be adults at least eighteen-years-old with no cognitive or intellectual disability, and have experience residing in an RTC located in the United States at some point when they were under the age of eighteen. Participants must have resided at an RTC for at least six consecutive months and be willing to verbally describe their experiences and perspectives about their transition from the RTC to their next placement. Post-RTC placements could have consisted of the participant’s home of origin, foster care, a Juvenile Detention Center (JDC), a group home, hospital, or
another treatment facility. Additionally, participation was contingent on the participant providing consent for their interview to be audio and video recorded and for their stories to be shared anonymously in the dissertation document and potential future publications.

All advertisements were approved by the University of South Dakota’s (USD) Institutional Review Board (IRB). Flyers were displayed on USD’s campus, public libraries, social media, and a state psychiatric inpatient facility. I asked known adult individuals who were enrolled in residential treatment as a child about their willingness to participate in the study. I also communicated participation needs to colleagues and asked that they distribute advertisement materials to eligible individuals.

**Data Collection**

Common among narrative studies, data was collected via multiple (i.e., between two and five) in-depth, individual participant interviews (Creswell & Poth, 2018; Kim, 2016; Reissman, 2008). I conducted all interviews and had good interviewing skills and worked to uphold the expectation that the participant is the “knowledge holder” (Kim, 2016, p. 158). I also closely supervised research assistants (RAs) who participated in data analysis.

**Human Subjects**

The study was conducted with the intent to uphold ethical guidelines outlined by the American Psychological Association (APA) and the IRB at USD which is accredited by the Association for the Accreditation of Human Research Protection Programs (AAHRPP). The study was proposed to my dissertation committee consisting of five USD faculty members with graduate status and extensive experience conducting and advising research projects. Upon committee approval, the study was submitted to USD’s IRB for approval prior to conducting any advertisement or data collection associated with the study. Guidelines were followed in effort to
protect participants from harm. Due to the collaborative nature of the research design, participants had the opportunity to ask questions and provided me with feedback about their experience participating in the study.

There were multiple amendments made to the IRB protocol due to the emergent design and change in methods throughout the study. There were also changes in research staff throughout the duration of the study which required IRB amendments. I stayed in close contact with individuals in the IRB office throughout the study and abided by all deadlines for renewal. The study was also audited by the IRB office soon after completion of data collection and passed with flying colors. All IRB approval letters are available upon request.

**Consent**

Prior to conducting any interviews, participants were emailed electronic copies of the consent form, asked to verbally confirm their confirmation of the consent form, and were asked if they were willing to proceed with participation which included audio and video recording over an online video conferencing platform (i.e., Zoom). The consent form stated the purpose of the study, pertinent interview and audio recording protocol, the benefits and risks of participation, and the voluntary nature of their participation. Participants were reminded that they can choose not to answer any question at any time, and that they have the right to discontinue at any time without risk of negative consequence. They were also provided with contact information for me and Dr. Caraway and offered the opportunity to review and verify their interview transcripts at any time. Participants were provided with confidential community resources had they felt the need to seek psychological services. They were also provided with guidelines about how to report abuse of a child and/or vulnerable adult if they felt that they had reportable information.
Funding and Compensation

Participants were paid up to $75 for their participation in the study. They were paid $25 after completion of one interview, another $25 after completion of three interviews, and an additional $25 after completion of a fifth interview. Funds were obtained from three sources which included two grants through USD and my personal funds. The Honorary Award for Excellence in Research, Service, and Leadership awarded $400 in 2020 through the Center of Brain and Behavior Research (CBBRe) through USD’s Graduate Student Organization (CGSO) to help fund this project. The second obtained grant was the Graduate Research and Creative Scholarship Grant which awarded up to $750 in 2021 through the USD Graduate School. One hundred percent ($400) of the CBBRe grand funds were utilized and approximately forty seven percent ($353) of the Creative Scholarship Grant funds were spent on study expenses. Funds were utilized to pay participants, buy qualitative data analysis software, and to pay for an electronic transcription service. I used my personal funds to pay for any study related expenses not covered by the obtained grants such as software for RAs and postage.

Confidentiality and Anonymity

All participant interviews were conducted via online video conferencing (i.e., Zoom), primarily due to the COVID-19 pandemic. I conducted the interviews in a private room which minimized the possibility of anyone overhearing the conversation. Participants were also encouraged to locate themselves in a private space when participating in interviews. All interviews were audio and video recorded via Zoom and a physical handheld audio recording device (for backup). Protocols for protecting recordings was strictly followed. Participants were provided with the opportunity to express concerns regarding confidentiality and anonymity. No such concerns arose over the course of the study. Participants were referred to by either their
participant number or by a pseudonym during all research activities. No personally identifiable information was recorded in disseminated materials such as this final dissertation document or any resulting publications. Participant pseudonyms were included in all transcripts. Other potentially identifying information such as participant place of employment, names of schools, usernames of online accounts (email addresses, online payment platforms), and names of cities and states were also redacted from transcripts.

**Audio and Video Recording**

Interviews were recorded via Zoom and a handheld audio recording device. The handheld audio recording device was separate from my laptop and cellphone and audio files could be directly uploaded to other devices when needed. Two recording methods were utilized each interview to ensure no data was lost if one method failed. Files that were recorded on the handheld audio recording device were either immediately uploaded to my laptop computer or deleted (if Zoom worked properly). All electronic audio/video files were immediately password protected upon completion of the interview. Audio files were also immediately uploaded to a password protected online transcription service, Temi.com, which provides speech to text audio transcription and claims 90%-95% transcription accuracy. The final Temi.com product includes a web-based transcript which can be edited and downloaded.

Password protected audio/video files were also immediately uploaded to a password protected USB drive which was stored in a locked safe in my home. Only Dr. Caraway and I knew the password to the USB drive and all other data storage platforms/devices. RAs were provided the password per IRB guidelines and on an as-needed basis for the purpose of data analysis. The password was changed after RAs were no longer affiliated with the study. Completed transcripts were also electronically password protected and stored on my laptop
computer, on Dr. Caraway’s USD issued computer, and on the password protected USB drive. All other data associated with the study such as memoing and procedural tracking are stored in password protected documents and are only accessible to me and Dr. Caraway. All files were named in accordance with the corresponding participant number and pseudonym, and there is no written identifying information associated with file names (i.e., participant names, date of birth, initials, age, address, etc.). Participants were informed of the audio recording protocol and asked to consent to participation verbally prior to beginning their first interview.

**Individual Interviews**

Initially, each participant was asked to complete at least three interviews with the option of completing more. After data analysis began, it was clear that more than three interviews per participant were desired, and as such, an IRB amendment was made (and granted) for permission to pay participants for more than three interviews. The goal of the first interview was to communicate the purpose of the study, obtain informed consent, build rapport, and ask the first set of interview questions. Participants were encouraged to share information pertaining to their experience(s) and perspective(s) transitioning out of an RTC as a child. The goal of narrative data collection is to obtain detailed accounts rather than general statements (Reissman, 2008). Therefore, the researcher must identify appropriate conversational openings during the interview to probe for more storytelling, especially if the story shifts dramatically. A common challenge experienced among narrative researchers is the necessity to relinquish control during an interview as the researcher should follow the participant down their story-telling path, allowing them to continue with their narrative “in their own way” (Kim, 2016, p. 165; Reissman, 2008). Although having a structured plan for participant interviews is important, this must not
discourage shifting in researcher-participant power, allowing for spontaneous participant storytelling (Reissman, 2008).

Moreover, although open-ended questions prove more successful in obtaining data, the specific wording of questions is less important than the researcher’s attentiveness and engagement in the conversation (Kim, 2016). Not unlike a therapist-client relationship, rapport and trust between researcher and participant is imperative for adequate data collection (Kim, 2016). Participants tend to offer more interesting and important information in subsequent interviews when compared with the first interview, assuming adequate trust and rapport has been established (Kim, 2016). Although good rapport is necessary, Kim (2016) warns against too good of rapport in which case the researcher is more likely to be influenced by their own personal biases. Additionally, researcher openness is important during the interview process and is considered much more appropriate in the context of the researcher-participant relationship than when compared with the therapist-client relationship (Kim, 2016). I aimed to establish an appropriate degree of rapport with participants included in the study. I then monitored the researcher-participant relationship through engagement in reflexivity throughout the study, which is discussed in more detail below.

During interviews, I strived to keep in mind that participants tend to offer information based on perceived researcher expectations. For example, if participants expect that the researcher wants terse answers in response to questions, they will provide such. Therefore, due to the collaborative nature of narrative research, the researcher-participant relationship must be carefully nurtured. The nature of multiple of interviews practiced in narrative research is also beneficial when fostering a collaborative, co-investigator relationship (Reissman, 2008). My
conduct was tailored to each situation for the purpose of obtaining high quality data and was made transparent via use of memoing, a procedure discussed in more depth later.

In general, interviews conducted for the purpose of narrative inquiry utilize open-ended comments and questions which aim to foster a conversational style and an interactive, informal, and trusting atmosphere (Creswell & Poth, 2018; Moustakas, 1994; Reissman, 2008). The interview questions changed slightly throughout the course of the study which was dependent on the interactional styles of each participant (Moustakas, 1994). The interview protocol reflects a semi-structured format with relevant open-ended questions which were conducted in English. Basic demographic information was obtained; however, the interview was designed to be as open and inquiring as possible. This format allowed participant(s) to spontaneously share pertinent information and stories from their perspective, which ultimately fostered the emergence of information.

The interview questions were informed by Kim (2016), Moustakas (1994), Reissman (2008), Creswell & Poth (2018), the broader literature, the preliminary study, the purpose of the study, the goals of the study, and the research questions. Common in narrative research, the interview questions are semi-structured in nature and were designed to guide the interview and to maintain direction (Kim, 2016). The questions were also designed to be open-ended and flexible for the purpose of allowing for emergence of new information and questions (Kim, 2016). Interview questions were not asked in a standardized order or manner to each participant. Rather, interview questions were asked in a manner that made sense within the context of the work with the participant and in a way that aimed to naturally evoke information within the context of stories. Due to the nature of the questioning, I actively listened to the participant and demonstrated flexibility and open-mindedness during the interview process (Kim, 2016). I also
engaged in memoing after each interview to ensure that relevant experiences, thoughts, and hypotheses were recorded and tracked throughout the study.

Interview questions were organized in a three-interview format. Some may question why this design was chosen considering that five of the six participants engaged in a total of four or five interviews. As mentioned, participants were asked to commit to participating in at least three interviews prior to beginning the first interview. In five out of six cases, the participant agreed to complete additional interviews as many of the interview questions were not fully explored within the three-interview structure outlined below. Interview questions were asked of all participants who completed at least three interviews; however, questions were asked in a different order and manner for the purpose of allowing for the emergence of stories. Thus, the below protocol was not strictly followed and was utilized in a flexible manner consistent with narrative research methods. I also utilized aspects of my clinical training to appropriately identify and determine how to guide and structure each interview to gather pertinent information.

At least initially, interviews were completed one participant at a time. Meaning, participant one completed four interviews. Once the first participants’ interviews were complete, participant two was recruited and all interviews were completed, then participant three was recruited, and so forth. Although this was the general practice, there was some variation to this structure based upon participant availability and IRB restrictions. For example, participant one initially completed four interviews and completed a fifth several months later, after the IRB granted permission to offer more compensation for more interviews. Additionally, participant four dropped out after two interviews and participants five and six completed interviews concurrently (but individually) because they were recruited at the same time. In general, my
focus was directed on obtaining high quality data, adhering to fair treatment of participants, and following IRB guidelines.

The first interview with a participant informed the questions guiding subsequent interview(s). All interview questions were asked after the participant gave verbal informed consent prior to beginning the first interview. The interview protocol can be found in Appendix A, Figure 7. The following questions are examples taken from each interview: “How did you come to live in a residential treatment center,” “How did leaving the RTC impact you?,” and “If your adult self could talk to the child you were when you left the RTC, what would you say?”

Data Analysis

Narrative data analysis can be conducted from four broad vantage points, all of which are a form of restorying (i.e., reorganizing of the data; Creswell & Poth, 2018). All narrative data analysis methods occur in the context of the obtained stories, and some may utilize a coding procedure (Creswell & Poth, 2018). Kim (2016) describes narrative data analysis as “a meaning-finding act through which we attempt to elicit implications for a better understanding of human existence” (p. 190). Analysis may include examining data from a chronological perspective with identification of epiphanies, important events, and turning points (Creswell & Poth, 2018; Denzin, 2001). Moreover, analysis may include analyzing elements of the story structure in the context of the plot such as identification of characters, setting, problem, actions, and resolution (Creswell & Poth, 2018; Yussen & Ozcan, 1997). Analysis may also utilize a three-dimensional approach which includes identification of story interaction, continuity, and situation (Clandinin & Connelly, 2000; Creswell & Poth, 2018). Finally, data may be analyzed by theme identification through use of coding (Creswell & Poth, 2018; Reissman, 2008). Throughout the data analytic process, the concept of “flirtation” with data was kept in mind (Phillips, 1994). Flirting with data presumes that
the researcher(s) will “undo our commitments to what we already know and question its legitimacy” as we do not preemptively know what will emerge from the data (Kim, 2016, p. 187).

The first component to any qualitative data analysis is appropriate organization of the data. Then, identification of an appropriate data analytic technique (Creswell & Poth, 2018). Data was analyzed chronologically and via thematic analysis through coding. Data analytic methods changed throughout the study due to the emergent and open-ended nature of the design. Per Kim (2016), data analysis only becomes clearer as the researcher “flirts” with the obtained data (p. 195). For example, the type of coding utilized was determined once the study was underway as it was based upon the data that emerged. Consistent with best practice, I referenced narrative methodologists throughout the course of the study to determine the most appropriate data analytic approach as the process unfolded (Kim, 2016; Saldaña, 2011).

Moreover, when conducting qualitative research, data saturation is accepted as the gold standard and entails collecting enough data so that no new knowledge is emerging, but rather is confirming what has already been discovered (Kim, 2016; Merriam & Tisdell, 2015). If data saturation is not obtained, this indicates that the phenomenon has not yet been entirely explored, an occurrence that is not inherently associated with invalidity (O’Reilly & Parker, 2012). Integrity measures are also imperative to qualitative data analysis to ensure that ethical principles are upheld and that the study’s procedures are transparent to the consumer. Finally, data representation is also an important component because the way data is represented to consumers must accurately reflect participant voices (Creswell & Poth, 2018). The following data analytic procedures were utilized: organizing the data, open coding, memoing, restorying, thematic analysis, use of integrity measures, and data representation.
Organizing the Data

Creswell and Poth (2018) present the qualitative data analytic process in a spiral image representing the circular nature of analysis rather than a linear process. Thus, the first step in the qualitative data analysis process is to identify appropriate data organization and management procedures (Creswell & Poth, 2018). Once organizational procedures are identified, they are utilized throughout the study. Audio files were organized per the guidelines described in the Audio Recording section. Audio data obtained from participant interviews was transcribed into password protected documents organized by participant number and pseudonym. A combination of electronic and human transcription procedures were utilized.

Audio files were first electronically transcribed by an electronic transcription software, Temi.com, which cost 25 cents per minute of transcription and claimed 90-95% accuracy. Once electronic transcripts of the audio files were complete, they were checked and corrected by RAs in Dr. Caraway’s research lab. All recruited RAs were treated as co-researchers and were trained in transcribing interviews by me. RAs accessed the electronic transcripts via the password protected, online Temi.com platform. Corresponding participant names, pseudonyms, and participant numbers were kept in a separate password protected file only accessible to me and Dr. Caraway. All RAs and necessary committee members were included on the IRB application and provided proof of up-to-date training completed through the Collaborative Institutional Training Initiative (CITI) Program. They were also eligible to receive research course credits and authorship credits on research poster presentations, oral presentations, and/or future publications associated with the study. Transcripts are inherently incomplete as they reflect only the spoken words of participants (Reissman, 2008). Therefore, the process of memoing (described in more depth below) was also utilized during the data collection and transcription process.
Once transcripts were complete, computer assisted qualitative data analysis software (CAQDAS) was selected. MaxQDA was the CAQDAS selection based upon factors such as operating system compatibility, cost, familiarity, organizational features, and collaboration functions. All coding was performed in MaxQDA by me and RAs, each of whom had access to the software. All transcripts were uploaded to MaxQDA and organized based upon participant and interview number. Codes were tracked within the software and collaborating researchers met weekly to discuss data organization and workflow. Additionally, I tracked all interactions with participants, co-researchers, RAs, the IRB, and advisors on a spreadsheet for ease of accessing information about communications throughout the study.

**Open Coding**

Coding was utilized to organize the data and to formulate narratives as well as themes observed across participants. Coding is defined as “a heuristic—a method of discovery—to the meanings of individual sections of data” (Saldaña, 2011, p. 95) which is most often “a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data” (Saldaña, 2021, p. 5). More specifically, open coding is typically utilized when the intent is to be “open to anything possible” at a certain point of analysis (Merriam & Tisdell, 2015, p. 204). More specific coding methods were then utilized for the purpose of constructing the narratives and identifying themes, which included selective coding and axial coding. The coding process took four months in duration.

**Research Assistants.** Although there were multiple RAs involved in the study, there were two RAs who were significantly involved in the data analysis process. During the data analysis phase, one RA finished his Bachelor of Arts degree in psychology and criminal justice at USD, took a job post-graduation conducting research projects, and was accepted to a doctoral clinical
psychology program (R. Vinzant, personal communication, April 23, 2022). The other RA was in
the process of completing Bachelor of Arts degree in psychology at USD and is working toward
psychology graduate school applications (A. Kunze, personal communication, April 23, 2022).
Both RAs completed one presentation about the study at local conferences. They both completed
assigned readings about qualitative research methods and participated in trainings that I
provided. They were encouraged to engage in discussion about the content of the literature, and
how it applied to the study. Each RA contributed to the study for research credit through USD,
however, they also contributed portions of their time voluntarily. Additionally, both RAs also
completed a summer internship working at an IPF, which were experiences that they brought to
the data analysis process. They often processed their experiences with the project and their
internship during our meetings, which added richness to their understanding of the data.

One RA and I each coded the data individually in MaxQDA and then met weekly to
discuss codes and observations about the data. During such meetings, codes were either
combined, collapsed within one another, cut, or kept as is. The second RA also attended all
meetings and provided feedback on open coding processes, however, focused primarily on
selective coding for the purpose of restorying (described below).

**Coding Methods.** Although two rounds of coding is considered the gold standard for
qualitative data analysis (Saldaña, 2021), one round of coding was completed because two
individuals independently coded the data concurrently. Additional coding will be conducted prior
to any future attempts at publication as this would further add to the rigor of the study and
validity of the findings (Saldaña, 2021). Please see the Integrity Measures section for more
information about the rigor of analysis utilized in this study.
There were several elements of coding utilized in the process which included lean coding (Creswell & Poth, 2018), descriptive coding, and “lumping” (Saldaña, 2021, p. 33). Lean coding refers to the recommendation that a researcher end with a maximum of 25 to 30 codes per dataset that result in 5 or 6 themes (Creswell & Poth, 2018). Descriptive coding refers to summarizing data into short words or phrases, which are typically nouns aimed to identify the main topic of the text/data (Saldaña, 2021). “Lumping” refers to “macro-coding” in which the broader topic of the data is the focus (Saldaña, 2021, p. 34). Use of the above coding methods were integrated and thus applied to generate the analysis of the obtained interview data. In general, the following coding guidelines proposed by Saldaña (2021) were followed: coding only essential parts of data, lumping, utilizing selected codes repeatedly, subsuming codes into broader categories throughout the coding process, and use of analytic memoing (described below).

**Memoing**

Memoing is also a process of creating short phrases and key concepts associated with the data (Creswell & Poth, 2018) which provides the researcher with opportunities to reflect on personal relations to the topic, the research question(s), code choices, emergent patterns, ethical dilemmas, and future directions, among others (Saldaña, 2011). Memoing served two primary roles in the current study including as an aspect of data analysis and as a validation procedure. Memoing allows ideas to be tracked over time and is considered part of the data “flirtation” process because the researcher does not yet commit to ideas, maintaining a degree of skepticism (Kim, 2016).

I utilized memoing immediately following every interview and upon review of interviews. To clarify, prior to conducting a subsequent interview with a participant, I listened to the previous interview and memoed before conducting a subsequent interview. Thus, memoing
was conducted on two separate occasions for every completed interview (immediately after the interview and upon review of the same interview, before the next interview). Memoing served as a form of processing the data and synthesizing meanings. I aimed to write about my reaction to various aspects of the interviews, ideas that emerged in the process, and plans for future interviews and/or data analysis. In sum, memoing served as an organizational tool by me to track the study and emergent design. In addition to memoing about the participant interviews, procedural and debriefing memoing was conducted throughout the study. Such procedures will be discussed further in the Integrity Measures section.

Restorying

Data was restoried through use of memoing, selective coding, and chronology (i.e., timeline analysis). Appropriate analytic methods were matched with the data to ensure that meaning was derived as legitimately as possible (Kim, 2016; Saldaña, 2011). The first element of restorying included transcription of the interviews and memoing per the process delineated above. Timeline analysis and selective coding were conducted concurrently with open coding because one RA focused primarily on reordering participant stories and identifying impactful and important events. Selective coding was utilized for the purpose of writing a “story line” that connects the categories and highlights interrelationships within the data to identify important events (Creswell & Poth, 2018, p. 88).

In conjunction with selective coding, chronology was utilized to create the scaffolding of each participant narrative which entailed chronological ordering of events described by the participants. The purpose of restorying the data into a chronological order is to highlight and integrate important events associated with the story so that it can be conceptualized as a “coherent whole” (Creswell & Poth, 2018; Kim, 2016; Polkinghorne, 1995, p. 15). Additionally,
chronological restorying helps explain potential gaps in the data and helps the reader understand “why and how things happened in the way that they did,” which fosters deeper understanding of the participant’s actions and perspectives (Kim, 2016, p. 197). Chronological ordering includes reorganizing and rewriting the data on a continuum of time and within participant context. Then, important and/or pivotal events, epiphanies, and turning points are identified in the context of story chronology (which are also identified via selective coding; Creswell & Poth, 2018). Restorying and timeline analysis was utilized to answer research questions one and two:

1. How do adults who transitioned out of an RTC as a child recount their experiences before, during, and after their transition?
2. Which lived experiences do these adults perceive to have been the most impactful in their life trajectory?

**Thematic Analysis**

Reorganizing the data by themes is also common in narrative research (Creswell & Poth, 2018; Reissman, 2008). The purpose of thematic analysis is to observe patterns in the data both within and between participant stories (Creswell & Poth, 2018; Kim, 2016; Polkinghorne, 1995). Identifying themes allows for a detailed explanation of the meanings associated with the stories (Huber & Whelan, 1999). Since each participant’s individual narrative was constructed, thematic analysis was conducted across participants to identify patterns and common themes that emerged within the entire dataset of this study. Thematic analysis was utilized to answer research question number three: In what ways have these adults integrated their experience leaving an RTC as a child into the broader context of their life story?

Axial coding was utilized to identify themes which allows for grouping of the open codes (Merriam & Tisdell, 2015) into significant statements, categories, representing clusters, or
themes that represent the data (Creswell & Poth, 2018). RAs and I collaborated to categorize open codes into categories, and eventually themes, which were responsive to the research question, mutually exclusive, exhaustive of the data, sensitive, and conceptually congruent (Merriam & Tisdell, 2015). After themes were identified, I engaged in formulating abstraction beyond the codes and themes (Creswell & Poth, 2018; Lincoln & Guba, 1985). Interpretations are linked to the literature in the Discussion section and compared and critiqued with existing research findings in the topic area (Creswell & Poth, 2018; Moustakas, 1994).

**Integrity Measures**

Consideration of data validation and reliability are especially important in qualitative inquiry due to the active participation of the researcher in data collection, analysis, interpretation, and presentation. The use of validation and reliability procedures throughout the course of the study are discussed.

**Validation Procedures.** Standards for validation of data interpretation are utilized for the purpose of preserving credibility, integrity, and rigor associated with the study. More specifically, the final qualitative product should represent the voices of participants and resonate with readers. Thus, validation procedures help ensure that the researcher has “gotten it right” and appropriately and ethically represents the participants. There are many ways to validate the data and subsequent findings including researcher self-reflection and reflexivity; triangulation of data; seeking participant feedback; generating rich, thick descriptions; pursuing external audits; pursuing peer review; and many other methods (Creswell & Poth, 2018). Creswell and Poth (2018) recommend utilizing multiple validation strategies (at least two) and clearly reference them regardless of the qualitative methods employed. Three validation strategies were utilized in this study which include perspectives from both the researcher and the reader/reviewer and are
discussed below. Moreover, participants were provided with the option of engaging in validation processes via transcript and narrative review. These strategies and processes were refined after the study was underway.

First, I participated in validation by engaging in reflexivity and striving to understand and communicate how personal biases impact the research (biases are described in the Researcher Positionality section above). Bias impacts much of the research process (data collection, analysis, interpretation, and presentation). My emotional reactions to participants had an impact on which stories to share, and how to share them. Some narratives were chosen due to the evoked emotion that the story had on me, and subsequently my anticipation about how the story may impact readers. The ways bias impacted these choices can be assessed through the lens of social constructivism and researcher positionality.

Second, written presentation of the research aims to provide rich, thick, textural description. Such writing style allows for readers to arrive at their own conclusions about the findings. Details are provided when describing participant experiences and interconnecting details observed in the data are carefully presented (Creswell & Poth, 2018). Data was reviewed soon after collection to ensure pertinent contextual information was included in the final document. Data review also entailed timely interview transcription and associated memoing. Prompt review of data allowed me to better remember participant stories, as well as my response to the interaction.

Third, I recruited a graduate student from my research lab to debrief through use of Socratic Questioning to ensure the study was being carried out as proposed. Lincoln and Guba (1985) describe this process as keeping the researcher “honest” with the debriefing individual asking difficult questions and providing the researcher with an opportunity to process and
problem solve. This practice is also comparable to interrater reliability measures utilized in quantitative research methods (Lincoln & Guba, 1985; Merriam & Tisdell, 2015). I summarized all debriefing meetings immediately after they were completed. The recruited graduate student was included on the IRB application and provided proof of up-to-date training via the CITI Program. I engaged in six, one-hour debriefing sessions with my fellow graduate student and summarized each meeting in writing. Debriefing sessions occurred during the data collection phase, and I scheduled debriefing sessions as needed.

Reliability Procedures. Reliability procedures are primarily focused on the accuracy of coding qualitative data and utilizing external “checks” of the coding process (Creswell & Poth, 2018). Obtaining agreement on assigned codes is imperative prior to data interpretation and deriving meaning. I conducted all coding procedures along with one RA and with the input of the other. I led a total of 20, one-hour meetings (approximately weekly) with the involved RAs during the four-month coding process and made myself available for needed consultation. Notably, Creswell and Poth (2018) and Miles and Huberman (1994) recommend 80% agreement on assigned codes. Once 80% agreement is obtained, the coding process will continue until data saturation is achieved. All researchers involved in the study negotiated difficult codes, worked to resolve disagreements about codes, and collaboratively identified themes. Thus, 80% agreement about codes was obtained.

Data Representation

The data representation process occurred throughout the study as analysis and interpretation involve textual construction. Conclusions are ultimately represented through use of reflexive writing and visual representation, when appropriate (Creswell & Poth, 2018). Kim (2016) describes the concept of “narrative smoothing” which emphasizes the importance of
balancing a “good story” with a “faithful account” of the participant’s experience(s) of the studied phenomenon (p. 192). Therefore, the goal of narrative data representation is to creatively display the participant stories in a coherent, engaging, interesting, and understandable manner without omitting important concepts (Kim, 2016; Saldaña, 2011; Spence, 1986). The final product should appropriately represent the stories and voices of the participants, an imperative component to conducting sound qualitative research (Creswell & Poth, 2018; Saldaña, 2011).

The data is presented in its restoried form which will highlight the identified epiphanies, events, and major turning points occurring throughout the narratives. The content will also be organized via themes which will reflect observed patterns across participant stories. A thick, rich, textural writing style is utilized as one component of the proposed validation procedures (Creswell & Poth, 2018).

Findings

Findings based upon the data are presented below via presentation of participant narratives and the themes identified across participants. The narratives aim to answer research questions one and two and the thematic analysis aims to answer research question number three.

Participant Characteristics

Participants in the study are diverse and will be described by general characteristics in this section. Characteristics reported in this section applied at the time of the interviews and are based upon participant self-report. In depth understanding of the participants’ stories can be obtained from reading their narratives.

One participant identified as a transgender man and the other five participants identified as cisgender women. One participant identified as lesbian, one participant identified as pansexual, two participants identified as heterosexual, and two participants did not identify their
sexual orientation. Four participants were Caucasian, one participant was Black, and one participant self-identified as Russian. Participant ages ranged from 20 to 28 years with one participant age 20, one participant age 21, two participants age 23, one participant age 25, and one participant age 28. During childhood, one participant experienced high socioeconomic status (SES), three participants experienced low SES, and two participants experienced middle SES.

Two participants reported being pregnant during their interviews and two participants reporting having one child at the time of the interviews. Three participants reported being single, one participant was cohabitating with a partner, one participant had a partner that they did not cohabitate with, and one participant was married. Additionally, two participants reported having a criminal record. One participant was a full-time college student, three participants were currently working and attending college, one participant was unemployed, and one participant identified as a stay-at-home parent with aspirations to go back to school. All participants had earned at least a high school diploma and all participants were monolingual. All participants also reported having career goals ranging from nursing, teaching, dental hygiene, restaurant hospitality, emergency medical technician (EMT), accounting, and law.

Interestingly, three participants were involved with the foster care system on at least one occasion during their childhood and at least four participants were involved with Child Protective Services (CPS) on at least one occasion during childhood. Two participants were adopted. All participants had siblings, however, only one participant lived with their sibling throughout most of their childhood. One participant had parents who stayed married, two participants had parents who divorced while they were children, and three participants had parents who were either never involved in a committed relationship with one another, were never married to one another, and/or did not stay in a relationship with one another. Five participants
described experiencing at least one traumatic event during their childhood. More specifically, five participants reported experiencing some form of maltreatment by a caregiver and at least two reported experiencing caregiver substance abuse. All participants reported having a previous and/or current mental health diagnosis and at least two participants were currently receiving some form of mental health treatment. Interestingly, two participants reported that their biological mothers were diagnosed with borderline personality disorder and stated that they each were given the same diagnosis as a child. One participant also reported having a severe medical illness as a child and two reported experiencing surgical procedures in childhood.

**Participant Narratives**

Each participant narrative is presented below. Pseudonyms are utilized and all potentially identifying information has either been redacted or altered with the intent to protect participant identity and confidentiality. Participant protection was the primary goal followed by the integrity of the research and compelling presentation of the findings. All text displayed in quotations and blue colored text are the actual words of participants generated from interviews.

**Fred**

Fred is a 23-year-old Russian, transgender man who uses he/him/his pronouns and was assigned female sex at birth. I had some acquaintance with Fred prior to engaging in a co-researcher relationship. During our five Zoom interviews, Fred met with me within the confines of his apartment that he shared with his partner, now fiancée, and soon to be spouse. At the time of our first four interviews, I was in my rental home in Beresford, South Dakota. At the time of our fifth interview, I was in my apartment in downtown Minneapolis, Minnesota. Fred often joked about his cats, and we typically made small talk about how our lives were drastically altered by the COVID-19 pandemic. All our meetings occurred during a time in which the world
was quarantined, and our weekly meetings satisfied only a fraction of our hunger for human interaction. Four, one-hour interviews were completed across four consecutive weeks in April and May 2020, while our fifth, one-hour interview was completed four months later, in September 2020. Fred was eager and open in his approach to storytelling and was delightful to work with. He expressed genuine interest and participated in the study out of hope that his “input could maybe help.” He also went to the same RTC twice, indicating that he may “have a little bit of a different perspective,” musing that “it’s good to think about your past sometimes.”

One of Fred’s most significant life events occurred at 9-months of age when he was adopted from a Russian orphanage by his family. His description of his homecoming was the first of many obviating the incredible support offered by his family and friends, support that would persist throughout his mental health journey as a child and adolescent.

So, they [Fred’s parents] went over to Russia, they looked in Ukraine too…they were just kind of like looking around and stuff and then they saw me and they’re like, Oh! We want that one. Yeah. So, whenever I came to the US my parents had a bunch of their friends waiting for them at the airport gate. It was crazy. I don't remember it obviously but like from pictures and stuff. It was crazy. This is back when they actually let you go to the gate. There was a bunch of just family members that we still see on Christmas.

Fred has a mother, a father, and an older brother, who is a biological child of his parents. He also has multiple biological siblings who were also adopted from Russia, but whom he has never met. Fred talked about his incredible family support during every interview. His mother was described as a very involved “momma bear” who was eager to learn about mental health and issues commonly experienced by youth identifying as LGBTQIA+. Fred remembered that his mother “literally has like half a bookshelf of adoption books, transgender books, rainbow books,
gay books, straight books, everything. She's got her own little psychology library… if you give
her any topic, she'll buy a book and learn about it.” Throughout his experience in the RTC,
Fred’s parents (particularly his mother) proved to be advocates, protectors, and supporters of
him. His family marched with him at Pride festivals and supported him throughout his gender
transition from female to male. Throughout our work together, I enjoyed Fred’s openness in
acknowledging his privilege. He enjoys his ability to “pass” as a cisgender man, appreciates his
high socioeconomic status of his parents, and experiences positive social support from his
family, fiancée, friends, and community.

Fred was first diagnosed with a mental health disorder at age ten and was first
hospitalized at age twelve. He recalled being diagnosed with “ADHD and anxiety” and
experienced significant difficulty during his middle school years, particularly after coming out as
gay at 14-years-old. The kids at his school “had no idea what that was all about” and as a result,
Fred was “terrorized so bad” and subsequently engaged in several suicide attempts. He was
“suicidal and very anxious and overwhelmed with social situations.” He was hospitalized “a
couple” of times in middle school due to the suicide attempts and self-harm behavior. It wasn’t
until his third hospitalization that he was first admitted to an RTC at 14-years-old, shortly after
starting high school, for a total of six months. The RTC that he attended served adolescents ages
13 to 17 years, and was located in a large metropolitan area. The facility was locked and housed
two coed units, although both units were comprised of primarily female-identifying patients.
Patients either had their own room or shared a room with another patient, although transgender
patients typically had their own room. Fred feels as though the RTC admission was necessary
and helpful despite also experiencing adversity as a result.
Fred’s first admission to the RTC “really helped with the self-harm thing, like almost a hundred percent.” The milieu at the facility was very structured and strict, something with which Fred initially struggled to adjust, but found helpful long-term.

…There's a lot of boundaries. Like you can't touch anyone, you can't talk to anyone unless someone else is listening. It's kind of weird. I didn't get it at first, but now I get it now that I'm older, but like, if you want that program to work, you have to have a good attitude or it won't work.

Additionally, some of the strict rules enforced in the RTC continue to impact Fred’s behavior today. For example, “…if you left your light on, you wouldn't get to go to the activity the next day cause you wasted the electricity. I don't leave my lights on in my house anymore, like ever.” Fred also recounted skills he learned from his time in the RTC, particularly as they related to organization and emotional awareness and regulation. Some of the coping skills he learned involved dialectical behavior therapy (DBT) and calming techniques. Others involved intense exercise, healthy lifestyle, and organization or structure of his schedule and living environment. Fred described that the RTC staff would “…make us move the chairs and we'd do 30 to 35 minutes of exercise. The old school like nineties workout videos, but they work, I mean they make you sweat.”

Fred’s first discharge from the RTC at age 15 was considered “successful.” He recalled that “when I first found out I could leave, I was like, hell yeah. Like I'm outta here. Let's go.” Upon discharge, Fred remembers coping well with his emotions. Although he did not necessarily associate negative memories with his first discharge, he stated that he “…did miss being around a bunch of people cause like at my house it was just me and my parents and the dog,” describing that the “activity level was definitely different” and that his home felt quiet. Fred also “missed
[his] friends and feeling safe too. Always knowing that, even though you're really in a facility, there was always like a safety net.” His new home environment also suddenly felt dark.

…This actually like dramatically affected me for some reason because they [the RTC] always had the lights on, I cannot sleep in darkness anymore. I thought there has to be a light on somewhere. I don't know why. Like my eyelids have adjusted to it at night, but like I always have to have the hall light open and my door always has to be open. It can't be closed. They just like instilled that into my memory I guess.

Other aspects that Fred missed from the RTC after his first discharge included playing “Walley Ball” and basketball at the YMCA, his social interactions with peers, his primary staff member with whom he described having a “positive impact,” watching old movies on DVD, and hearing music come from the rooms of his peers on the unit. Although he missed these aspects the first time, he did not miss much of anything about the RTC after his second discharge.

Fred’s aftercare initially consisted of him returning to the RTC on a monthly basis for follow-up sessions with the facility’s psychologist. At these meetings, Fred checked-in about his use of coping skills, progress of family therapy, and frequency and severity of self-injury or suicidality. Fred was even allowed to visit his peers from the RTC one-month post-discharge as long as he was doing well. Fred’s parents were also given instructions for aftercare including ways to gradually increase his freedoms and responsibilities as he adjusted to being home. He recalled trying other psychotherapeutic treatments post-discharge including Eye Movement Desensitization and Reprocessing (EMDR) and “normal talk therapy.” Despite doing well for a period of time, Fred began to struggle with significant mental health symptoms again which he later attributed to his felt mismatch between his physical body and gender identity. He eventually started to regularly use drugs (Codeine, cannabis, and pills) and engaged in several more suicide
attempts prior to his second admission to the same RTC. Fred came out as transgender (“Fred”) to his parents during this time.

I came out as Fred, I instantly felt better and my parents were like, that's fine. You know, you're still our kid. We still love you. Go get the help you need. Literally, that's what they said when they took me to the treatment center. So yeah, I lucked out with my support system because there's some people there that don't have anything. They have like maybe a grandpa or grandma, that's it…So, yeah. I feel like if I did not have the support system, it probably wouldn't have gone this way.

Between his two RTC admissions, Fred was also hospitalized for one and a half months at a facility he described as “pretty terrible” following another suicide attempt. He then transitioned from that hospital directly to the same RTC, where he stayed for four months.

During his second admission, Fred embraced a different attitude and perspective about treatment than he had the first time. He was in the process of officially transitioning his gender and recalled witnessing alarming behaviors from his peers. He remembers his second discharge feeling different than the first as he was more eager to leave, which was influenced by the unit frequently being on “lockdown” and his desire to focus on his gender transition.

Unlike his first RTC discharge, Fred’s second discharge was deemed “unsuccessful” because his insurance company stopped funding the treatment after four months. Since Fred had started treatment at a specialized gender and sexuality clinic while he was at the RTC, his insurance company would not pay for two concurrent treatments. To Fred, his second discharge was successful, and perhaps more successful than his first because he felt as though he was finally getting the treatment he needed.
After his second discharge at age 16, Fred legally changed his name and gender to align with his male identity. Shortly thereafter, he started presenting as Fred socially. His father was particularly helpful and supportive of him when navigating the legal process of changing his identity. Something Fred is grateful for to this day.

…Coming out as Fred, like literally is what I needed to do. And just the fact that my parents are so awesome about it. My entire family is so cool about it. That was probably one of like the most positive reactions I've ever gotten…I really got my self-confidence. That's when I started actually being okay and being able to breathe without walking on eggshells.

As Fred continued to work with the gender and sexuality clinic on an outpatient basis, he also transferred to an alternative high school, which was a better fit socially. He then quickly sought out gender affirming surgery, however, initially experienced another obstacle. His “top surgery” was initially denied due to his history of suicidality and self-harm. He recollected the impact that the surgery denial had on him.

I don't know why I have to live with this. I was just so fed up and I was already kind of doing drugs too, so I wasn't in a good state of mind. I had a really bad suicide attempt and I almost died…I took like 30 Oxycontin pills and it was bad. I was high for like a week. I was not supposed to live, but they got me to the place fast enough. Got me detoxed. Yeah, it was bad like my mom's all gray hair now because of that.

After his recovery from the suicide attempt. Fred and his parents changed course and sought out a different gender and sexuality clinic. He saw specialty providers who quickly approved his surgery and operated within a couple of months. Fred reiterated that by the time he sought the surgery, he knew the primary cause of his mental health difficulties: his physical
appearance did not align with his identity. He recalled that “when I did get my top surgery, everything was just better.” Shortly thereafter, at 17-years-old, Fred met his current fiancée who he described as having “…been my rock. She's gone through everything with me.”

Much of Fred’s perspective about the long-term outcomes associated with his RTC treatment pertained to his experience of coming out as Fred and having confidence to be open about his identity. His time in the RTC served as a catalyst for his transition process, which proves to be the most important and impactful experience in his life. Without having gone to the RTC program that he did, Fred does “not think I would have come out and if I did, I don't think it would have been as soon…Cause I wouldn't have like searched and like actually allowed myself to feel that amount of sadness.”

His RTC experiences also impacted him in other positive ways.

I'm definitely a lot more patient with people and I have a lot of compassion because I know what some people can go through. Especially surrounding depression and anxiety. I guess I'm more personable now, like with my family I'm more…before I kind of would just sit there and be like, okay, I'm here. But now it's not really a problem. I interact with them all the time….For friends I feel like I have a better sense of judgment with people, especially when it comes to substance abuse and people that don't make good choices. So, just cutting toxic people out of my life. That's been a lot easier lately. I'm more motivated and I have self-motivation. Before, I didn't really understand that too much. I just thought you had to do things because you had to, not because you wanted to. I just have a better head on my shoulders. I was really screwed up before and this helped a lot.

Fred also talked about his increased comfort with “being weird” and embracing the things that he likes regardless of what others think. His treatment also helped him realize that it is “okay
to be different” and that things can change for the better with time, stating that “I’m worth more than I thought I was.” He feels as though his outlook is more positive than it was prior to treatment as he tends to see more of the good than the bad.

Fred recently graduated with a bachelor’s degree and has a job he enjoys in his field of study. He is planning a wedding and continuing to engage in healthy activities, many of which were ingrained as habits during his time in the RTC. He enjoys spending time with his friends, family, and fiancée. Fred’s willingness to consult about the study and review materials was greatly appreciated, and he hopes that others may learn from his story.

Lexy

Lexy is a 23-year-old white, cisgender, heterosexual woman who uses she/her/hers pronouns. I met Lexy through a mutual colleague during the recruitment phase of the study. She was initially hesitant to participate because she was fearful to talk about her past, much of which is traumatic. Despite her reservations, she wholeheartedly engaged in the process and was quite pleasant to work with. When Lexy and I met, we were both preparing to move across state lines, although her move was a much larger undertaking than mine. We also engaged in conversation about how our lives were impacted by recent disasters including the COVID-19 pandemic and the riots in Minneapolis, Minnesota after the murder of George Floyd in May 2020. Our relationship felt mutually beneficial and supportive.

We engaged in a total of four one-hour Zoom interviews across four consecutive weeks spanning the months of May and June 2020. During our first interview, Lexy was physically located in a West Coast state at an Airbnb rental home. For the first interview, I was in my rental home in Beresford, South Dakota. For subsequent interviews, I was in my apartment in
downtown Minneapolis, Minnesota. Lexy was friendly and kind, while also clearly curious and interested about the study and topic area.

I definitely have a lot of experience in it [the topic area]...and I guess my interest is that it was all horrible...I think I just see a lot of faults with it [RTCs], but obviously I was also a teenager, so I'm sure that my opinion of it was very skewed...So whenever I saw like your baseline of trying to improve it, you know, for hopefully future generations, I was like, yeah, that sounds about right.

During subsequent interviews, Lexy and I were both settled into our new homes, her in the South and me in the North. We tended to connect over the way in which our dogs were adjusting to their new environments and how efficiently each of us could travel to the closest grocery store in our new respective cities. At the time, Lexy had a 2-year-old daughter and was pregnant with her second child.

When asked to tell her story, Lexy described growing “up in a Christian home out in the country.” She was homeschooled during her elementary school years and described being taught strict Christianity, explaining that her parents didn’t “believe in doctors” and taught her that:

God is a dictator and he's going to punish you...and my parents use the Bible verses to skew them as much as possible so it's like ‘honor your father and mother, they say to do this, like you better do it, otherwise you're going to get lightning struck on you or something.’

Lexy later attended public middle school and during this time, became critically ill at 13-years-old. As a result, professionals became involved with her family which greatly impacted her life. Lexy described that “no one really saw that [dysfunctional] part of our family” prior to
her need for critical medical care, as her family was socially isolated. She recalled the onset of her illness.

I was throwing up blood at school and the nurse was like ‘you guys [to Lexy’s parents] need to bring her in, like something is wrong.’ And they refused to and then the school was like, we'll get social services involved if you don't. And so they did and then they found out I needed open heart surgery. About a month later I got it and just because of my parents' track history, I didn't feel safe with them being in the room while being super sedated and being in ICU…

Lexy described that the discovery of her heart condition and her need for critical medical care unveiled her mental health difficulties. Her doctors and nurses raised concern about her wellbeing and health of her family system, which included her mother, father, and six siblings. While in the hospital, Lexy’s four older siblings:

…All flew back from home and stayed with me in the hospital, and they never had my parents there alone with me. And so, the surgeons thought that was super weird…So, they brought in a psychologist and that didn't go very well, and they were like, she needs to get out of the house now. And so, the only way that they released me is if I moved in with my sister who lived in [Westcoast state].

Since Lexy was unable to fly on an airplane after her surgery, she stayed with a family who was affiliated with her church for a couple of months until she recovered enough to fly to live with her older sister. During this time, she finished her school year online. Shortly thereafter, Lexy explained that “my parents got a divorce because of my open-heart surgery. And cause that brought to light a lot of issues, I guess, excuses.” For example, Lexy recalled that her mother had previously threatened Lexy that if she did not help pay for her incurred medical costs, that
she may not be able to receive the lifesaving heart surgery. Lexy described her father as “very
good at manipulating and making himself look like this prime, amazing person when he's really
not.” She then recounted the trauma she endured at the hands of both her parents. She watched
her father “beat” her brother when they were children, which resulted in her experiencing “a lot
of PTSD” and “flashbacks.” Lexy’s mother was verbally and emotionally abusive toward Lexy
and her siblings when they were young, as she’d often “tear you down and tell you how horrible
you are of a person.” However, once Lexy or one of her siblings turned 12-years-old, their
mother tended to “get kind of scared of you…stops parenting you and kind of just starts avoiding
you all together.” Whereas Lexy’s father “becomes excessively controlling” during his children’s
teenage years.

Despite the abusive behavior displayed by both of her parents and the extensive trauma
impacting her entire family system, Lexy’s mother was presented as the abusive parent by her
father during their divorce proceedings. Even more painful was that Lexy felt as though the
divorce was blamed on her (due to her heart condition). Moreover, since her mother clearly
suffered from mental illness (Borderline Personality Disorder, Anorexia, PTSD, among others),
Lexy’s father swiftly obtained custody of Lexy and her two younger brothers as he was better
equipped to present as a capable parent. Lexy then moved out of her sister’s home and in with
her father, at which time she started taking antidepressant medications.

After moving in with her father, Lexy was hospitalized in an IPF at least 15 times during
the ages of 14 and 15, primarily as a result of suicide attempts and self-harm behavior (cutting).
She attributes her psychiatric hospitalizations to the abuse she suffered from her parents, stating
“about half the time it [her suicide attempts] was mostly like I don't want to be around parents
because it's too intense and I didn't know how to identify that.” She went on to describe the treatment approach utilized by the hospital program.

…no one ever said I had PTSD or I had complex PTSD and you know they were like no she has borderline or she has this but I was too young to officially diagnose it cause they always saw my dad as the good guy cause he brought her in. But, you know, they never dug. And I understand they have to deal with the behavior cause they don't want you to kill yourself before they actually figure out what the problem is. But, I was living with the abuser…so they weren't ever getting to the root of it. It was always just a quick Band-Aid to treatment, get her to stop wanting to hurt herself, get her to stop cutting, and then we'll send her back home. And so, that happened for many years. And then eventually after all the inpatients at the hospital and the day treatments they are like, this isn't working, we're going to send her to residential.

Lexy was admitted to an RTC at age 14, where she stayed for 8-months. The RTC that she attended was located in a large metropolitan area, was a locked facility, and housed two coed treatment units. She recalls feeling afraid and confused during treatment, and tried her best to fly under the radar. Family therapy was one aspect of her treatment and Lexy “never understood why I was in therapy with him [her father]” as she was too afraid of her father to disclose her true experiences to anyone. Furthermore, despite exhibiting obvious fear around male RTC staff members, she doesn’t recall staff or therapists attempting to learn why. She believed others noticed and thought that:

…Lexy won't talk to any guy therapist and Lexy won't ever be alone with a guy tech just cause she's so terrified of them, which they all knew, in which we identified multiple times in individual therapy, but they never like clicked it enough to be like, ‘yeah, that
should be a little bit of a red flag’…I just think that there was such a huge spectrum and because I stuck to myself and because I was just a shy kid that was terrified of over half of the staff, which were men, I flew under the radar. I didn't get in trouble, you know? And the only reason why the attention would be on me is because if there was a suicide ideation at all that the individual therapist detected, then they would take everything out of my room that could be a weapon or a self-inflicting thing. Other than that, they didn't really interact with me very much.

Many of Lexy’s memories associated with her time at the RTC related to the limited lighting in the facility, lack of color on the walls, and it “just being super, super creepy all the time. Like a very, you know, eerie feeling.” She often felt uncomfortable around her peers and had limited confidence in staff ability to keep her safe. Due to her frequently being on suicide precautions (at least half of her entire treatment), Lexy also felt as though her peers were “hateful” toward her because they were required to adhere to restrictions when around her (as her roommate). Lexy also missed out on activities that may have helped boost her mood and self-confidence such as going to the YMCA, and other group outings off the unit (theme parks and grocery stores). Instead, while on suicide precautions, Lexy felt as though she was “extra secluded in an extra dark place with extra creepy people,” which she did not find at all helpful for her mental health.

Approximately three or four months into her RTC treatment, Lexy’s insurance company decided to stop her funding. Her treatment team did not believe she was ready to discharge, so she was admitted to an IPF hospital for a short period of time until her funding was sorted out. She remembered that IPF experience as being “completely opposite” because the unit felt bright and colorful rather than “gray and poop colored.”
After returning to the RTC from the IPF, Lexy realized that she “just needed to get out of that place [the RTC] because that place is not making it any better.” She then felt determined to exhibit the behaviors that RTC staff were looking for, “to skid by enough that they felt comfortable with releasing me,” regardless whether such behaviors aligned with how she truly felt. She stopped disclosing her suicidal thoughts to her therapist and feigned positive thoughts and feelings. She remembers thinking that “whatever I need to tell the therapist is what I'm going to say to get out” as she preferred to be at home with her parents, as abusive as they were. After some time of “skidding by” in treatment, Lexy felt as though staff believed that “she made so much progress” and were subsequently “patting themselves on the back” even though “90% of that was BS cause [she] was so terrified of living there.” Lexy recalled interactions that she had with RTC staff members prior to her discharge process, as well as thoughts and feelings associated with such interactions and perceptions about her treatment.

…the family therapist and individual therapist kept on saying [to Lexy] like, ‘wow, something switched and you just got better overnight.’ And they kept on saying that and I was like, ‘good for me. Like that is great. Right, right. Exactly.’ And in the moment I was like, ‘wow, I'm great at my job. Like, I am great at getting out of really crappy situations.’ And so they kept on saying that and they sounded so genuine. Like, ‘wow, you actually care about yourself now.’ And I remember the social worker saying that too, she's like, ‘I've never had a kid recover from going so deep to so great.’ And she's like, ‘really, you're a success story.’ And I remember just being like, ‘wow, I am really great.’ And really all that shows, is like how horrible they are at their jobs.

Lexy’s aftercare plan involved her participation in a day treatment program and a plan to permanently live with her father. To Lexy, it all “sounded great” and she hoped it worked
because she felt comfort in knowing that suicide was her “plan B.” Recalling the state of her mental health at the time of her discharge has left Lexy “in awe of like, wow, you guys [RTC staff] are like kind of really stupid.” Her discharge celebration was equally disappointing and was a major event that Lexy remembers well.

…at the very end the staff would make you this glorified scrapbook, like of your time at [RTC]. And I remember about a month before I was getting discharged, they kind of knew that they were going to have me go. And because I hadn't gone on like any of the outings, they had no pictures. So, this entire scrapbook is filled with pictures between like three days of us like doing walks around the [park] and wearing almost the same outfit every single time. And it's all in winter. And I remember it, like I was so sad whenever I saw it. And I remember the staff member who was doing it had to stay extra late cause she was having to get them [the pictures] developed that night…And them [the staff] making this whole scrapbook and stuff. And like all [the patients] have goodbye talks and stuff and I didn't get it [a goodbye talk] with over half of the staff because it was so quick of a discharge…So yeah, I just remember being like, you guys really had no idea who I was. You guys never got to know me…And I still have it [the scrapbook] and even looking back at it…What a sad little time that you guys needed to go out and do these extra things just for Lexy so that we can get pictures whenever I was there for almost a year. So, I think that was one of the biggest takeaways is like, you guys really didn't get to know me on the level of, other than like a checklist of like she's good, like she’ll do good enough to make it.

Overall, Lexy felt as though her discharge from the RTC happened fast and she fully anticipated having an easy experience in day treatment as her previous experience with such
treatment proved to be “a joke.” Per discharge instructions, she also stayed on suicide precautions at home and had a “nanny” at age 15, which Lexy found to be somewhat embarrassing. In general, she felt as though her family was unprepared for her discharge and that her treatment team did not know how to truly help her.

After her RTC discharge and completion of day treatment, Lexy described her transition back to public high school, where she completed 10th grade, as particularly challenging due to the lack of educational rigor she experienced while in school at the RTC.

…I feel like going back to [public High School] was so hard…I wasn't going to tell all those kids or even the teachers like, ‘hey, I've been coloring pages for the last nine months, and I passed. So, I'm in the next level.’ And so, I feel like that was really hard. And the assistant principal at my new high school, my dad talked to her and was like, ‘hey, she just came from a treatment center.’ So, I don't know exactly why, [but] like she checked in a lot, which was super weird. I don't know if they thought I was gonna be a trouble student or what, but very much lots of check-ins even they were like ‘you feeling okay?’ Like, ‘is today a good day?’ Like, ‘is anyone bullying you type of deal?’ And I'm like, ‘yeah, assistant principal, I don't want to talk to you, like who are you?’ But I feel like academically and even now that's one of my biggest ‘dang it’ moments. I could have done APs [advanced placement college courses] and, I did college in high school my senior year. And they just really pushed down [at the RTC] like, ‘well you're so depressed, just obviously you're going to fail at school. So let's just give you the bare minimum to get by’… I mean, again, you can do a coloring page and it would be like ‘great, good job.’ You know? And I loved school. Like that was my outlet. It always has been. So I started asking the teachers at [Treatment Center], I was like, ‘give me
homework.’ I remember them being like, ‘oh no, we don't want to add to your stress level.’ And I'm like, ‘no, I like homework.’ But I think, again, if they would have gotten to know me and [been] like, ‘hey, that's her outlet. She's a depressed kid, but she actually likes to learn,’ that it would have definitely helped my self-esteem. Even staying back from all of the excursions instead of just sitting there in a depressing dark room writing in my journal compared to ‘give me whatever, like give me research or like give me, you know, books or anything’ just to advance my knowledge.

Several notable events occurred after Lexy returned to public school. Her father got remarried to a woman that he had known for only a month, she was hospitalized in an IPF another two times, completed another day treatment program, and eventually moved in with her mother. She remembers meeting her stepmother for the first time at her father’s wedding. She also remembers her father acting very concerned about their family image as it pertained to Lexy’s mental health difficulties.

I used to cut and so he found blood all over one of my sheets and cause we were moving in with his new wife and he didn't want her to see it, he’s like ‘you get to pay for this, so pay for this. Now we just throw it out. Don't let her see it but just, you know, you can't do that anymore. Like we're a good family now.’ And so, in the moment I'm like, ‘oh, that's weird.’ Like really, I'm like, ‘you found a bunch of blood on my bed and your first response is we need to pay for the sheets? Because we don't want [wife's name] to see it?’

After her two additional IPF admissions, Lexy completed her third day treatment program which was heavily focused on DBT. She has particularly negative memories of DBT associated with both day treatment and the RTC.
I feel like I got like nothing out of it and like I never really understood it cause they would just do it out of binders, like as a group therapy. And it's like, ‘okay, read this page. Okay. Read this page. Okay. Let's fill in the blanks’…And it's very wordy and it's very much so like, ‘okay let's turn to page two. Like, this is how you do it,’ you know? And just kind of like real stupid stuff. Like whenever you're in that mindset, you were just like, ‘okay, this is ridiculous. Like I'm not going to go be mindful right now. I don't need this,’ or you know, just like the different types of like suggestions they have. They're so simple, but just the extent of it, I was like, ‘I don't want to do this because I deal with it better my way.’

Lexy recalled a particularly painful memory associated with DBT that occurred while she was in the RTC. She had previously witnessed a traumatic death of a church member and was struggling with the trauma.

…One of the day staff came in [Lexy’s room] and they were like, ‘oh, what's going on?’ And I kind of explained it and they're like, ‘Oh, you need a grief worksheet.’ And she literally left my room, went into the office, grabbed this grief worksheet, handed it to me and she's like, ‘you should do this.’ And then she walks out and I remember just being like ‘you idiot, I don't need a worksheet. Like, can you just sit with me in silence?’ And I guess they weren't allowed in the room necessarily unless we walked out of the room…But like, don't hand me a freaking worksheet of grief to work through something. And so, I feel like that was so much of their approach is just like, let me add this to your binder. Where I'm like, that's not what I needed…It's like, just think of what any human would have needed in that moment. They would've needed human contact of some sort.
Like, I know they couldn't physically hug us or anything, but like just be with me in that moment and be silent.

After completing her third day treatment program, Lexy moved in with her mother which is what she felt she needed at the time. Her mother was largely uninvolved which allowed Lexy freedom to engage in desired activities. She then completed 11th and 12th grade at an alternative high school that she applied for on her own. She remembers that she had a “graduating class around 200 and you have like four core teachers that you see for half of the day. And so that was something that I really was so excited to go to.” There, Lexy “thrived.”

…That's how I got enough confidence from the teachers… they really invested in you and they really liked it. And so, I would just secretly go up to them and I'm like, ‘so in the syllabus there's like five words I have no idea what they mean. Like can you just break those down for me?’ And they were so great about it just cause they're like ‘the kids that go here, a lot of them are druggies, but also a lot of them are like very passionate about, um, like topic centered schooling for like the environment,’ that they would really invest their time in you.

Due to the alternative school structure of her new school, Lexy had opportunity to study under medical professionals at a Pediatric Intensive Care Unit (PICU). Such experiences aligned with her goals as she aspires to become a nurse. Lexy became interested in nursing in part due to her positive experience with a special nurse who helped her through her heart surgery. She also described that:

…If someone tells me I can't do something, I get very interested in it. And because my parents were like, ‘we don't believe in doctors or hospitals,’ I was like, ‘perfect, that's my new niche. That's what I'm going to do.’
Lexy successfully graduated high school, moved across the country to work as a live-in nanny at age 18, got married at age 20, and gave birth to her daughter at age 21. Her spouse works for the coast guard, so she frequently relocates due to his job. Therefore, her aspiration of completing nursing school and/or EMT school has not yet been achieved. She has also ceased contact with her father after slowing putting up relational boundaries with him for the purpose of her own wellbeing. One of the most impactful experiences in her mental health journey was her engagement in EMDR at age 22. Lexy described seeing a therapist who finally identified her diagnosis as “complex PTSD” and provided appropriate treatment. When reflecting on her childhood overall, Lexy starts “instantly thinking of mental health hospitals.” In general, “getting out of residential treatment wasn't that big of a deal...it just kinda happened…and it felt like it happened really fast.” To Lexy, her marriage, the birth of her child, and major moves across the country are her biggest “life changing moments.” However, her experience of postpartum depression in adulthood reminded of her of mental health difficulties from childhood.

I feel like that was probably the biggest wakeup call, is that it's not one and done, like you probably have to deal with this [depression and anxiety] for the rest of your life, and it will probably just come in certain seasons. But I feel like I had a really good stretch for four years, like not being on any medication and really being just fine without a therapist and all that stuff. And then as soon as I had [daughter] and the postpartum and everything, like it went straight back to, you know, residential status mentality, like mental health wise. And so, I feel like that was super shocking 'cause I was like, ‘are you kidding me? Like I went through all this treatment. Like why, why is it coming back at all?’ And so, I feel like that was just a major, like shocking, like, ‘Oh crap, this is a lifelong potential battle...’
In general, Lexy does not feel as though her time in the RTC was worthwhile, although, she does value her newfound appreciation for psychotherapy. She shared her opinions about her RTC treatment outcomes.

I don't feel like I got a lot out of it. I think I realized the value of therapists in the sense of like, I wasn't afraid to be like, ‘yeah, I need a therapist now.’ You know, even whenever postpartum started, really hitting there was little waves of denial of like, ‘yeah, no way, like I'm fine, you know?’ But then I think if anything, it helped normalize, it's okay to see a therapist. You know, you're not crazy if you do. And so, I think that was probably one of my biggest takeaways. Besides that, it's mostly just one of those just like scary type of things that you just don't talk about. Even my whole family knows that it happened to me…But like, we just don't talk about that part, we don't talk about those years. I still have no idea, like any significant things that happened for those two, two and a half years…Or like my brothers didn't see me for almost a year and a half during that time. And so, it was just like, but I don't know what happened to you guys and we're just not going to talk about it, you know? So, I feel like that’s the kind of stuff that I took away that was like a negative. And even whenever I had talked to this new therapist in [West Coast state], like, especially cause it was like PTSD, like EDMR type of stuff. And so, a lot of like the old, like suicidal ideation came back up and a lot of it was super intense at some points. And it just terrified me at the thought of going back to a hospital, even though adult hospital, you know, it's very different I'm sure. But just like the thought of it. So it made me super hesitant to be really honest with him [therapist] about what was really going on cause I'm like I've already been down that route. Like you cannot sugar coat it. Like it's not, it's not fun. And I don't want to do that, especially with, you know,
having a daughter and not being able to be around her or see her and all this stuff. So, I think that that made recovery take a little bit longer in [West Coast state] just because, not that he ever threatened it by any means, but in the back of my mind, I was like, if I say too much, like he's gonna, you know, like hit the red button. So yeah, I think if anything, it really just made me super weary of being completely honest with the therapist, knowing like how far they can put you.

Lexy also emphasized the importance of mental health providers getting to “the core” of the issue. She described multiple times that the many mental health workers with whom she had experience as a child didn’t dig enough to figure out what was truly going on. She even expressed experiencing fear at the thought of participating in this study as she did not want to reactive old traumas unnecessarily. When asked, Lexy shared feeling that my experience working in RTCs “brings some security to being like, ‘okay, like she's had experience in knowing this stuff enough. And, you know, especially with the other people that she's interviewing.’” She stated that she would not have continued with interviews had she felt unsafe. In light of the incredible effort and commitment that Lexy made to this study, I can only express my appreciation for her and feel honored that she trusted me with her story.

Lexy hopes that RTCs can be improved for children as she identified that many kids she met while in the hospital and/or the RTC “…kept on coming back. I knew these kids by name. All of the staff knew me by name and they were like, ‘Oh Lexy, like nice, you're back. And I'm like alright, like I'm back.’” Although she maintains that her experiences with the mental health system as a child were generally “horrible,” she feels like she is doing well as an adult and is proud of her therapeutic work thus far. She wanted to better her life for the sake of her family.
Lexy hopes that others may learn from her story, and I have no doubt she is a positive light in the world for those with whom she comes in contact.

Kate

Kate is a 21-year-old white, cisgender, lesbian woman who uses she/her/hers pronouns. She contacted me about participating in the study after seeing a recruitment flyer on a college campus. Her eligibility for participation was initially questioned because she attended an RTC as a child for the purpose of her biological mother’s substance abuse treatment, and not for treatment herself. She is included in the study because she identifies as an adult who transitioned out of an RTC as a child and meets all other participation criteria. Her stories were not only unique, but rich and informative. Moreover, her perspective is one that may frequently be overlooked in this field of research, as I admit to initially feeling surprised by her perspective and identification with the study.

Kate and I engaged in five, one hour Zoom interviews spanning across seven consecutive weeks (meetings ranged from one to two weeks apart) in August, September, and October 2020. We often engaged in small talk about her life on campus and how we were both coping with the COVID-19 pandemic, sometimes even joking about how we each handle the urge to cough while in public. During the interviews, Kate was sometimes in her dorm room and other times she was at her adoptive mother’s apartment. During all interviews, I was in my apartment in downtown Minneapolis, Minnesota. When I met with Kate, she instantly put me at ease and expressed openness and kindness in all interactions. She also had a noticeable flair of maturity for a person her age. When asked about what compelled her to participate, Kate explained that:

I was just kind of reading it [the recruitment flyer] and, and I was like, ‘well, what's an RTC?’ And so I looked it up and immediately my mind went back to my time at the
center and I was just like, ‘I've always wanted to be a part of a study, but now that I'm older and I look back on my childhood, I want to share some of my experiences in hopes that maybe some kids that were in my situation can get the help that they need.’

Kate was studying to become a teacher when we started our co-researcher relationship and explained that:

…it took me a long time as an adult to realize that what happened when I was little wasn't what most kids went through. And that's also why I want to be a teacher. Cause I want to be able to stand up for the kids and show them that they're not alone. And that things happen and that they can get through it.

When recounting her background, Kate self-identified as an “accident child” of her biological parents because her mother, Tara, was 40-years-old, and her father was 45-years-old when she was born. Kate is also the youngest child of each of her biological parents, who she both describes as alcoholics. Kate has four older half-siblings, 2 on her maternal side, one brother and one sister, each of whom have different fathers and were both adopted by separate families. She has 2 brothers on her paternal side, who are full siblings to one another and raised primarily by their biological mother. Ironically, her paternal half-brothers’ mother also happened to be one of Kate’s teachers when she was in high school. Kate’s biological father has been largely uninvolved in her life, and her biological mother (Tara) has struggled with alcoholism for many years. Kate also has an adoptive mother, Sandra, who has been an incredible support for Kate since she was born.

I was raised by my mom [Sandra], my quote-on-quote aunt. She was just a family friend who took me in when I was in the foster care system. And then my mom got sent to
prison. And instead of going back to the foster care system, I was old enough to sign away my rights to be adopted by my adopted mom.

Tara and Sandra also have a long-term friendship with one another, historically exemplified by conflict. Kate described that Sandra “doesn’t like my mom’s alcoholism” and “hates” Kate’s father with “a burning passion.” Sandra largely perceived Kate’s father to have had a negative impact on Tara. However, Kate maintained throughout our interviews the incredible, positive impact that Sandra has had in her life, as Sandra was even present for Kate’s birth. Sandra’s home is Kate’s home. Despite the difficulty in Sandra and Tara’s relationship, Sandra served as Kate’s primary parental figure for most of her life. Kate also described that Sandra consistently advised Kate to maintain relationships with her biological parents and has been vigilant about not replacing their roles in Kate’s life.

Prior to relocating to a northern Midwest state, Kate, Tara, and Sandra lived in a southern state together until Kate was 6-years-old. Once relocating, Kate and Tara lived with Kate’s biological father and his wife, and their two sons (Kate’s paternal half-brothers). During this time, Tara had been cycling in and out of substance abuse treatment centers due to alcohol addiction. Kate recalled that “sometimes she'll go to a different treatment center, stay there for a couple of weeks, be let out and then she'd get into trouble again [for driving under the influence], they'd take her to another one. It just was like a cycle.” It wasn’t until adulthood that Kate was able to differentiate the reason for her mother’s starkly different behavior when intoxicated versus sober. As a child, Kate “…didn't really see the problems with my mom [Tara] because she is my mom. And as a child, I never saw a problem of my mom drinking. I knew the difference, but I didn't know what was wrong.” Although Kate knew what alcohol was, she didn’t recognize
that alcohol was the reason for Tara’s obvious and frequent change in behavior. Kate recounted early memories associated with Tara’s drinking.

I remember when I was little, little, like maybe five, at least maybe six…before we went to the [RTC]. Where we were living with [Sandra] in this house, mom [Tara] was sleeping in her room and I didn't want to go downstairs and get something to drink. So, I went into her room and she has this gray glass, which, you know, now thinking back on it, it's always been her wine glass or alcohol glass. I went to it and it was clear liquid. And I was like, ‘mom, can I have a drink of your water?’ And she just goes, ‘yeah,’ she's out of it, she wasn't paying attention to what I was saying. And I drank it and I just spit it back out it was so bad. And I was like, ‘mom, this was your alcohol!’ And I knew it wasn't water. And I knew that mom drank it, but I don't think I associated that with what she was.

Notably, when Kate was 7-years-old, Tara was admitted to an RTC substance abuse treatment center, and Kate lived with her there for one year. Their admission was the first and last time Kate ever attended treatment with Tara. Prior to her admission, Kate recalled that Sandra:

…came up to me cause I was staying with her at the time. And was like, ‘you're going to have to go stay with your mom.’ And I'm like, ‘oh, where is she?’ And she's like, ‘she's up in [City]. You'll have to live up there with her.’ I'm like, ‘okay.’

At the RTC, all the parents admitted were mothers with children. The children represented all genders, ages, and backgrounds, and they resided in a space that was “…basically a giant dorm, children live with their parents in a room.” Kate remembers feeling “…nervous the most…out of my element. It just didn't feel right. I guess I just felt I didn't belong there. I
wanted to go back home. I wanted to be with my friends. I wanted to see my dog.” When asked to describe the RTC further, Kate recalled that the primary reason children were included in the treatment was to “…make the mothers grow closer with their children” and Kate recalled that her role while in the RTC was to:

…bond with her [Tara] and remind her that alcoholism isn't a good choice for a mother with a child. Usually when I would help her with therapy, I would go in and tell her, I guess, experiences of when she would drink around me.

Kate mostly remembers feeling “alone and uncomfortable there [at the RTC]” and was “…a part of some of her [Tara’s] treatment, but I don't think I was really involved too much.” Kate does not recall having any of her own individual psychotherapy or treatment while in the RTC because most of the programming was focused on the mothers. However, Kate did recall participating in family therapy.

I would tell them, like, ‘I remember when my mom [Tara] would not play with me and wouldn't do this and she'd be drinking here and there.’ And then they'd write it down. They'd say, ‘do you have any feelings you want to talk to your mom about?’ And I would say ‘oh, I thought this and that and I wish you had done this more when I was little.’

Kate also acknowledged that “a lot of my memories are not very linear, especially during that time up at that treatment cause I really hated it up there. So, I think I blocked a lot of those moments.” In general, her time in the RTC reflected “the worst year of [her] life so far.” One of the most difficult adjustments for Kate was moving from a rural town where she frequently saw Sandra and felt safe, to an RTC with Tara located in a large city, which felt overwhelming and unsafe.
[I was] completely upheaved from the life that I had in my hometown to live in this communal area with people I don't know. There had been people who had threatened me, adults. I didn't like the school. They made me go to a summer school just because they didn't want the kids running around the center the entire day during the summer. So I struggled really hard those years until we were able to leave.

Kate recounted an early experience she had while in the RTC, one which perpetuated her felt sense of threat while there.

...one of the worst things I remember is me and some of the other kids playing ‘house’ or something and it escalated to me accidentally scratching a girl on the back, you know, like kids playing around and getting a little too rough. And I got pulled aside by the people that ran the center and they were basically like interrogating me being kind of rude. Like, ‘do you know how many scratches you left on her? Did you know that you made her bleed?’ And I felt awful. And I left and the mother of the child that I scratched saw me and called me a ‘little bitch’ and rushed to come hit me. And I had my mom and a bunch of other parents block her off and they ended up, I think they were sent home the next day.

In general, Kate recalls minimal adult supervision of the kids who were largely “left to their own devices.” Kate also felt uncomfortable and awkward spending time with Tara in the RTC while she was sober, although Kate gained new and positive experiences playing with her.

...growing up, when she would drink, she didn't want to play with me because, you know, it's a lot of work to play with kids, and you know, she didn't have the energy and she was too tired or she wasn't up to it. Or, her famous line that she would always tell me is ‘let's not and say we did.’ And you know, I would just accept it when I was little…I
would even repeat it to her. Like at one point I'd come up to her and I'd be like, ‘mom, do you want to play?’ And she'd be like, ‘Oh honey...’ And I'd just go, ‘Oh, let's not and say we did.’ And then I just walk off because I was just so used to it. So being around her in the RTC, when she would spend time with me, it was like some of my best moments. Cause we didn't really have that before.

Kate described another painful memory from the RTC which has impacted her into adulthood, and also highlights her feelings of loneliness and discomfort while there.

I remember one time the kids were supposed to have this movie night out in the lobby and I was so excited. I would get to talk to all of the other kids. And I thought it would be a chance for me to actually make friends so I didn't feel as alone. And well, when I went out to the movie, it was 'Click', the Adam Sandler movie. And I can't stand watching that movie cause every time it makes me cry…I was just sitting in this giant lobby by myself, the rows of couches, beds, watching this movie, crying to myself while everyone else is in their rooms. And it was just a very sad time.

Kate also described negative memories associated with her school environment while at the RTC. She felt uncomfortable there and missed the consistency of her school in her hometown.

I remember it as like a prison because it just had these high fences and an area with a lot of buildings and no trees really. And it was so different to what I was used to in [hometown] where it's just grassy fields everywhere...the school was different.

Despite largely disliking the school she attended, Kate also recounted some positive memories. She described having been placed in a “combined second and third grade” classroom and fondly recalled that “…they had a courtyard and they had honeysuckles and we would just
eat them during the recesses.” Kate also fondly described some of the kids in her class which was perhaps an outlet for her and a way to feel some semblance of normalcy.

…I was friends with people who'd like make up stories and they taught me how to finger knit and all of these cool things. And I thought it was fun just because I got to hang out with all of these people that I felt normal around.

After one year in the RTC, Tara was “kicked out because she started drinking again” after bringing alcohol back to the facility when she was allowed on outings to attend work. Subsequently, Sandra picked up Kate and brought her home while Tara was taken directly to jail. Kate does not remember much about her RTC discharge, stating that “[Sandra] said that it happened right away.” Kate believes that her discharge was “probably very instantaneous” once Tara was caught with alcohol. Kate does remember “…sitting with all my stuff and they're [RTC staff] like, ‘we're going to miss you, Kate. [Sandra] will be here to pick you up soon.’”

Once discharged, Kate officially entered the foster care system. Sandra worked toward becoming a licensed foster parent while Kate was in the care of another family. Kate was placed in one foster home that was recommended by Tara for a couple of months. Then, Kate’s father took her out of that home and placed her in foster care with his sister (Kate’s paternal aunt). Soon thereafter, Kate moved in with Sandra as her foster child. Kate later returned to live Tara “for a little bit” until Tara “got in trouble” again and went to prison. Kate was then officially adopted by Sandra when she was 15-years-old.

In addition to some of the hardship that Kate experienced while at the RTC, another memorable experience she had while there proved to have a profound impact on her sexuality. Tara’s views also played a role in Kate’s perception about sexuality throughout her childhood. Tara was described as “very Christian with locked in ideals when she drinks…that homosexuals
are bad.” Kate also shared that Tara “assumed that if I [Kate] knew anything about any kind of sex that something bad was going to happen to me. And so, she tried to keep me innocent.” Therefore, Kate was not taught about sex and was strongly cautioned to avoid anything potentially sexual in nature. Her worst and most painful memory related to her sexuality, occurred while in the RTC, and involved Tara.

I had an interaction with another girl and I used to think back on that time as like one of the worst moments because we were both young…but we did sexual things that we shouldn't have done at that age. Cause we didn't know better. Cause you know, my mom, she wouldn't tell me anything about sex. All I knew was that a man and a woman have sex. And so we thought, let's practice for our husbands. And after that happened, we got caught by my mom kissing…We both got in trouble and that's where I saw it as wrong because my mom freaked out…I was hysterical. I was like, ‘mom, mom, don't tell the other mom don't tell her. I didn't mean anything. I didn't mean to do it’…I just felt like I was an outcast and I was doing all these things that I shouldn't have been doing…After that, I hated thinking back to that moment, I felt gross. I felt disgusting. And then I grew up thinking I'm asexual. I don't want to have any sexual partner. I don't want anyone to touch me or try to have sex with me. I don't want anyone or anything. But I guess that moment, it really cemented my problems with my own sexuality.

Since then, Kate has worked on embracing her sexuality and is more confident in her sexual orientation as lesbian. She clarified that despite what she was taught as a child, she now understands that romance and attraction does not always result in sex. She attributes much of her development and understanding in this area to the internet and her ability to learn about sexuality online. She also struggles interacting with Tara at times because Tara assumes anything related
to sexuality will result in sex, and will subsequently result in Kate getting hurt. Kate explained that Tara experienced sexual trauma herself during childhood, and therefore, Kate has some understanding about where Tara’s views regarding sexuality originate.

Currently, Kate’s mental health is fairly good, however, she reported being diagnosed with ADHD while in middle school and subsequently taking Adderall medication. She also referenced experiencing anxiety as an adult and feeling as though she “overthink[s] everything.” She described often being her “own therapist in [her] head” and often links her current mental health struggles to early, adverse experiences as a child. Kate earns good grades and has an associate degree, and was on track to graduate with her bachelor’s degree when we met. She recently made the Dean’s List at her University, an accomplishment that Sandra did not let Kate minimize. Kate has also already started thinking about ways to help her students gain motivation and appreciation for school as Kate remembers often foregoing homework assignments that seemed trivial or caused anxiety.

Upon reflection, Kate does not feel as though her time at the RTC was “worth it” because things did not get better for her and Tara. Instead, “as soon as [Tara] was able to get a job outside, she immediately started drinking again.” Tara continues to drink alcohol and Kate has learned to set firm boundaries with Tara for the purpose of protecting her own wellbeing. Between our interviews, Kate talked with both Sandra and Tara about their experiences associated with the RTC. Tara tended to have different memories than Kate and recalled some information about that time.

I [Kate] had told [Tara] some things that we talked about and I mentioned like, ‘you remember that girl that I scratched and the mom’ and [Tara’s] like, ‘oh yeah, I saw the mom a couple of years later at a recovery march.’ I was like, ‘okay.’ Then I mentioned
the girl that I kissed. And she [Tara] was like, ‘I thought it was a boy.’ And I was like, ‘no, mom, it was a girl.’ And she was like, ‘Hmm. I thought it was a boy. I remember it being a boy.’

When Kate was invited to share more about her thoughts related to Tara’s differing memories, Kate shared her belief about why Tara remembered Kate’s sexual encounter at the RTC differently.

I think it's because [Tara] didn't want to think that it was another girl. So she remembered it another way. But I have a lot of deep memories, like specific details about it, about how we started, which was to prepare us for our husbands...She [the other girl] did have breasts, she was a girl, she didn't have a penis...and it's like, I remember all of these details of like, ‘that definitely wasn't a boy,’ but she [Tara] was like, ‘no, I remember it being a boy.’ I was like, ‘okay, mom.’

When expressing empathy and compassion for Kate and her experiences, she often reminded me that although many of her experiences in childhood were difficult and sad, she also practices an impressive degree of acceptance. I appreciated her openness and kindness throughout our co-researcher relationship and was always impressed by her resilience. She hopes that her story may help advance the field and help other kids who are in a similar situation that she was as a child. I am personally thrilled that she raised her voice to represent children who attended RTCs for the purpose of their caregiver, as I believe her story serves an important role within this study. I have no doubt that Kate will be a teacher who has a profound impact on her students and a person that does good in the world.
Jill

Jill is a 28-year-old white, cisgender woman who uses she/her/hers pronouns. She learned about the study from a recruitment flyer presented to her while admitted to an IPF. She initiated participation in the study shortly after being discharged. Jill initially appeared nervous and shy, and gave short answers to questions, sticking close to the point. However, she was much more talkative during our second interview, and we made small talk about what we were each doing for Christmas in the time of COVID. Jill and I engaged in a total of two, one hour Zoom interviews across two consecutive weeks in December 2020. During the first interview, Jill was located at her sister’s home and during the second interview, she was located at a friend’s home. I was located in my apartment in downtown Minneapolis, Minnesota for both interviews. Although we had a third interview scheduled, Jill was unfortunately re-hospitalized at the same IPF and unable to attend our appointment. Although she contacted me to apologize for missing our appointment, I was unable to get in contact with her to complete subsequent interviews. Jill’s story may be less detailed than others due to us only have two interviews, however, her experiences are important to share. She was the only participant who spent at least six months in an IPF as a child. Jill did not feel completely sure why she chose to participate in the study but shared that at the time of her discharge from an IPF as an adolescent, “my aftercare after leaving [IPF], wasn't like, particularly put in place.”

At the time of our first interview, Jill had moved in with her older sister four months prior, describing that:

…I had been living in [big city in different state] for like 10 years. And then, um, I don't know. I wasn't able to maintain employment at the time and my meds weren't working
and I don't know, I wasn't really following through with my treatment plan. And so I…moved into my sister's house for just the extra support for a little bit.

Prior to her difficulty with holding a job, Jill had filled multiple roles at a restaurant and held that job for multiple years. After she left her restaurant job, she struggled to hold a job for longer than six months. She has also been admitted to the same IPF a total of four times, once at 16-years-old for 6-months, once at 18-years-old for twelve days, and twice at 28-years-old with one admission lasting approximately two and a half weeks.

As a child, Jill primarily lived rural, and moved from her rural hometown to a different rural town at 15-years-old. She has one older brother and one older sister, a mother, and a father. Her parents were married until Jill was 24-years-old, although they experienced a tumultuous relationship when Jill was in adolescence. Jill had minimal contact with her family up until approximately one year ago. She currently has a close relationship with her sister but keeps a distance from her brother, largely due to maltreatment she experienced by him. She also described “getting along” with her father and does not often see nor talk with her mother.

One of the most impactful experiences in Jill’s life thus far was when she was involved in a serious car accident with her mother at 15-years-old. Jill’s mother suffered a traumatic brain injury (TBI) and was in a coma for approximately six months after the accident. After coming out of the coma, Jill’s mother was admitted to a residential rehabilitation facility (RRF), where she stayed for one year to recover. Although Jill’s mother lived with her family at home for a period of time after returning from the RRF, she later transitioned to a nursing home, and then to her own apartment where she receives in-home nursing care.

While Jill’s mother was in recovery at the RRF, Jill described “constantly going from house to house” because her father felt like he “couldn’t handle [her-Jill].” She lived with an
uncle, family friends, or some of her older friends who already lived on their own. She described the mental health difficulties that her father felt he could not manage.

I was really depressed, and I would just sleep all day and I wouldn't go to school. And then I also had some substance abuse problems. He [Jill’s father] just, he didn't know like how to discipline me or help me.

Jill was initially admitted to an acute IPF after her first suicide attempt at 16-years-old. She was discharged and then continued to struggle with her mental health, and particularly struggled to attend school. She then attempted suicide again, was readmitted to the same acute IPF, and then admitted directly to a different, longer-term IPF at 16-years-old, where she stayed for 6-months. Jill explained that she was diagnosed with “PTSD before I went to [the longer term IPF]. I had tried to kill myself twice within six months and after the second [suicide attempt], that's when I was admitted into [the longer-term IPF].” Her mother was also still recovering in the RRF at the time of Jill’s suicide attempts and Jill believes that she developed PTSD in response to their car accident. Jill also recalled being diagnosed with “depression” as an adolescent. As an adult, Jill has been diagnosed with bipolar disorder and borderline personality disorder (BPD). Although she remembers mental health professionals talking with her about her having BPD when she was an adolescent, she recalls being informed that she could not be diagnosed with the disorder until she was at least 18-years-old.

When Jill first went to the longer-term IPF, she remembers feeling very overwhelmed and somewhat fearful when being asked about her mental health in “technical terms,” and with no parent present.

I think mainly, it's overwhelming and they asked me questions, like, ‘do you do like self-harm’ or ‘do you have an eating disorder?’ And all of these things that, like, I had no
idea what they even were…It was really confusing cause I would just have to ask them, like, ‘I don't what that is.’ But I also didn't want to ask them that because I didn't want them to think that like, I'm stupid or something…I feel like it's kind of scary too because you see some patients freak out.

She described other memories associated with her admission at age 16 and her realization about what the IPF staff members classified as self-harm.

When I first got there, they do like a skin check and that to me felt like an overwhelming thing because you're having this stranger check all of your skin and you don't really fully understand the reasons why…. it was just kind of like ‘here, put this gown on’ and then they just start like looking at your skin. And they're asking like, ‘wait, where'd you get this scar’ and ‘where'd you get that scar?’ And then it starts to come up that some of them, for me, were self-harm…I didn't fully understand what self-harm was because I would burn myself, but I didn't understand that that was self-harm until that. I felt like, ‘oh, what am I getting myself into?’

While at the IPF, Jill spent three months on an adolescent mental health unit and 3 months on an adolescent chemical dependency unit. She described impactful interactions with peers while there.

…interacting with like the other teenagers that were there. I felt like, because we were teenagers, people were more focused on relationships and stuff like that. And then there would be girls that would get into arguments. And I was like so scared to be on the wrong side of that, that like, I would put on a façade and be somebody that I really wasn't to fit in with these group of people that I'm living with for a while…just trying to be cool and act like I don't care about the things that they're implementing to get better. Or like, you
know, if some girl that thinks that she's gonna get into a fight with some other girl and she's like, ‘Oh, do you have my back?’ And I was like, ‘yeah,’ but I have never been in a fight or anything like that.

Substance abuse was another difficulty for Jill, and she described how social factors impacted her attitude and response to treatment.

I did a lot of stuff with chemical dependency and I was really miserable when I was at home and like, I was drinking really frequently and I was really miserable. But once I was there, I'd be in these group sessions with other kids that also had chemical dependency problems. I would kind of act like I didn't need it, like I didn't need to learn more, I didn't need to change the behavior when really, I did want to.

Jill admitted that as her treatment progressed, she began to learn that “…when I would get honest and share how I really felt in those group therapy sessions, other people would share things too. And I felt like those connections were a lot stronger than pretending like you don't care.” There was one reading that Jill remembers from her substance abuse treatment at the IPF which also resonated with her after treatment.

…This one particular reading talked about how there's something that changes in your brain, like this click, after you have a certain amount of drinks and at that point you want to keep going. And I remember reading that and then once I got out, the first time I drank, I recognized that right away. And even when I was 17, I was like, ‘I'm going to have to stop this eventually, because I'm recognizing these things, these warning signs of what an alcoholic experiences.’ And I think if I hadn't ever been taught any of that information, I wouldn't have ever thought there was a problem.
Regarding her education, Jill remembers enjoying school at the IPF, as she completed 11th grade while there. She caught up on her academic credits after she fell behind on her credits prior to her admission.

Well, it was alternative school. So, I would just have individual assignments within English and math, and I feel like maybe history. And so, it was really helpful to just like, sit down and just do that homework or talk to one of the teachers one-on-one about things I didn't understand.

Although Jill learned some skills that she carried forward after her discharge from the IPF, she also learned negative behaviors that became habit for her.

Um, well honestly, didn't know what bulimia was until I was there. But like, I definitely restricted on a regular basis and like, but I didn't understand that that was an eating disorder. And then I remember when I'm taught that like, that's something that people do, I'm like, ‘Oh, well this would help.’ And then I would start engaging in that behavior.

Although Jill was engaging in restricting behavior prior to her IPF admission, she learned about purging while there and continued to engage in purging behavior post-discharge. She recalls having learned that purging is “a tool people use to help not gain weight.” She also remembered having “picked up on tips” for purging from another patient. Jill continued purging until she was 20-years-old. She also recalled replacing her tendency to drink or burn herself with purging.

Other memorable experiences associated with IPF treatment included Jill’s requirement to participate in “family sessions.” She recalled feeling surprised by her therapists’ insistence that she talk with her father about a traumatic event.
…My dad was there when my brother beat me up. Like he [dad] like watched the whole thing happen and so it wasn't like, new information for him, but like, they [IPF therapists] made me talk about it with him and them. And that was really uncomfortable because like, he [dad] was really mad that I had told them.

Jill also recalled a family session in which her mother joined, something that she felt very uncomfortable with as Jill did not “ever want to be around [her] mom,” and intentionally “didn’t visit her very often.” Jill also described that she would “fight my dad every time he would try to make me go visit her [mom].” Jill recalled the IPF therapists working to prepare her for times in which she may have to interact with her mother, and thus, they brought Jill’s mother onto the unit, something with which Jill was displeased.

…They [IPF staff] gave me a week's notice and I'm really ashamed to admit it, but I was really embarrassed about the situation. And I didn't want her [mother] to come on the unit…I didn't want the other patients asking me questions about the situation and what happened and things like that. And so, I asked them [IPF staff] if they could do it in a meeting room outside of the unit. And they said yes, but I think they just wanted me to see that the other kids were really supportive because they actually brought her onto the unit and I was really, really mad about it. But, before it happened, they had this isolation room with just a foam ball. And I would sit in there for hours that week, just throwing that ball at the wall, over and over again. Cause like, I really didn't want to deal with it.

Jill was pleasantly surprised by the reaction of her peers to her mother’s condition, and was appreciative of the support they offered. She also recalled that she “didn’t really focus on anything in session because I was so mad at them [IPF staff] for lying to me.” Despite her anger
about the situation, Jill also admitted that she found the family session helpful overall as she found “some closure from it.”

When asked about her discharge experience, Jill described feeling as though she didn’t have adequate aftercare services in place. She also recalled participating in a “home visit” prior to discharge. In general, Jill described her transition as challenging.

I remember they told me I had to tell my dad where all of my alcohol and other substances, like, where I was hiding them before they would let me do that home visit. And [the goal of] that home visit was to be able to leave. And I remember I was like, ‘I just won't go then’ cause I didn't want to lose those things [substances]. Eventually I did. But then once I was discharged completely, they set up outpatient services and it was in a town that was about 40 minutes away from where I lived. And I never followed through with those appointments. I took my meds for the month prescription that I had and then I never went to a doctor and got them refilled or I never went to the therapist. I don't really know why. I just felt like I had gotten so comfortable with all of these very strict, like there's restrictions and there's always somebody there telling you when to eat, when to take your meds, when to do all of that stuff. And then all of a sudden I was thrown back into the chaos [at home] that I was in before I went there.

Jill went on to describe the difficulty she experienced with caring for her mother who had transitioned back home during Jill’s IPF admission. Jill felt as though she “got stuck” taking care of her mother and didn’t have anybody telling her “you need to go to these appointments.” Jill admitted that she “would just go back to the old behaviors.” She remembers her father being “gone a lot” as he was having an affair with another woman at the time, and when Jill attempted to reach out to IPF staff for help and advice post-discharge, Jill remembered that she “…called
them once because I was really struggling, and I felt myself wanting to act on negative behaviors…talking to them on the phone wasn't the same. And so I never called again…it was just kinda awkward.”

Interestingly, Jill did attend Alcoholics Anonymous (AA) meetings post-discharge as they were more accessible than mental health treatment. Since she lived in a rural area, AA meetings were closer in proximity to Jill than mental health care. She feels as though access to case management would have been helpful and made her transition more successful.

In general, Jill feels as though her experience at the IPF was positive, however, the transition out of the hospital in some ways negated the progress she made.

I felt like leaving there I had felt like I had grown when I was there. I felt like I had grown because I had time to process a lot of things and work on things. And so I felt like when I left I was going to be more prepared to handle life outside of there. And I think to a sense it did help. Like, it definitely helped with my relationship with my mom and I was able to be around her and be as supportive as I could, but then there were new things that like, I didn't know about. And then they were just kinda like thrown in my face once I was home. And so I wasn't prepared for those situations.

Jill was referencing her obligation to care for her mother when she got home due to her father’s frequent absence. She feels as though if she was not “given resources” and positive coping skills while at the IPF, that “things would have been a lot worse” for her long-term.

Although contact with Jill was lost to follow-up, I believe in her ability to heal and manage her mental health. I was struck by her willingness to share her story and ask for help when needed, which was apparent as early as 16-years-old. She shared with me her goal of becoming a
paraprofessional in a school setting for the purpose of helping kids. This is something I could see her thrive in and I have no doubt she has great capacity to positively influence others.

May

May is a 25-year-old black, cisgender, pansexual woman who uses she/her/hers pronouns. She was recruited for participation in the study by a colleague conducting research with a similar population. May participated in five, one hour Zoom interviews spanning across six weeks (meetings ranged from one to two weeks apart) in December 2020 and January 2021. May met with me while in her home that she shares with her 5-year-old son. She was typically either located in a closet in attempt to evade her son’s bids to play, or she sat in her bedroom that displayed a beautiful tapestry in the background. I was in my apartment in downtown Minneapolis, Minnesota for all interviews. May was immediately friendly and relatable, portraying infectious enthusiasm and humor even through a computer screen. She was also obviously attentive to her son as he sometimes interrupted our meetings with requests for snacks or with attempts to persuade May to let him eat candy. May shared that she appreciated being able to participate in the study “…honestly kind of for selfish reasons…It's cool and everything…to be able to like go back through it. And like, there are certain things that I completely forgot about that have happened to me.”

When we met, May talked about some of the recent stressors in her life such as recently being fired from her job after incurring a legal charge for driving under the influence (DUI) of alcohol. However, she obtained a new job soon before we met that she “absolutely love[s].” She was without a job for a total of one day which May described as “the coolest thing ever.” Her new job was also remote which was important to her at the time because she had recently become her son’s primary caregiver after her son’s father was sentenced to prison. Since her
son’s father had been living off disability benefits, he had been the primary caretaker for their son while May worked full-time. May and her son’s father were not in a romantic relationship, however, experienced a positive co-parenting relationship.

May also expressed her appreciation multiple times for how things worked out for her. She was especially thrilled by the helping nature of her new job, which aimed to connect people suffering financially due to the COVID-19 pandemic with needed resources. Throughout our interviews, May was very open and transparent with me about her mistakes, her current difficulties, and her successes. I also found myself floundering when trying to choose which stories to share in this text, as May thoroughly captivated my attention with her stories. In general, May struck me as being fun, compassionate, honest, and quite frankly, someone who I would want as a friend.

May is one of seven children in her family, all of whom primarily grew up in the foster care system. All her siblings are full biological siblings, 3 of whom are older, and 3 of whom are younger. May proudly reported that “I’m everyone’s favorite.” Prior to entering foster care at age 8, May grew up in an abusive home with her six siblings and their mother. Their mother had visitation rights for the first two years that they were in foster care, however, she eventually lost her parental rights when May was 10-years-old. May and her siblings were eventually separated within the foster care system, but “secretly” stayed in touch with one another, as most of them were placed in homes located within the same city. Several of May’s siblings eventually ran away from their foster homes and most of them frequently “bounced around from home to home” and/or were in and out of various facilities. May described what she believes to be a common experience among all her siblings.
I don't think anybody got out [of foster care] without any sort of sexual or physical abuse happening and it just is freaking crazy, you know, cause, the thing is, I know there are really good foster homes and there are really good people who work in group homes, like I know that they're out there and they exist. I just feel like, we all really got the short end of the stick somehow…And they're [her siblings] all trying to heal too in their own ways. And I don't agree with some of it, but whatever, we're all trying.

Incredibly, May stated that her siblings “…didn't have to try to find our way back to each other, but we all chose to” and they continue working on forming and maintaining relationships with one another. They have a bond May described as “I want you in my life, but it's also like, we didn't grow up together. So, we don't know each other very well.” May described “we're trying to [have a bond], but it's just weird because we're like friends who don't really like each other, but we love each other.”

May and her siblings’ Child Protection Services (CPS) case was “filed under abuse/neglect.” She described her experience in her home prior to being placed in foster care.

…There were times when the lights weren't on. We always had food, we went to the laundromat for clothes and stuff. I don't know where the abuse came from, which is weird because, don't get me wrong, my mom abused us...We'd get beat every single day, but no one ever knew about it. So, for us it was the norm, that's what happened. We haven't experienced anything else. But my big sister…she was 13 and got pregnant by someone who was 21 or 22 cause my mom…a single mom with seven kids…was at work all the time and so there were these neighborhood people, I think they were in there to fix up the house or something, these two older men. And so they were there a lot and one ended up having a relationship with my sister, my sister got pregnant. And then I think that her and
my mom had some stuff going on, which I didn't even know about. But apparently my sister went to foster care a couple of times before we all did. So apparently CPS was already involved. And then my oldest sister was on probation, which once again, I had no freaking clue. So yeah, so the technical thing was abuse, neglect. But my mom was very abusive and she's crazy. Cause she's like, ‘that never happened.’ And like, you've you got five of your kids to be like, ‘hey Mom, remember when you did this?’ And she's like, ‘that never happened.’ Alright dude, like, we're all telling you…Mom had stupid ‘all for one and one for all’ rules. Like if one of us messed up, we all got whoopings. And so, I mean in the house of seven kids, someone's always messing up. So basically, the routine is my mom would come home from work, she would find something that is out of place or wrong or something that upset her or whatever, or someone fucked up somehow. And so, we'd all line up and we'd all get spanked. And I mean it was a belt or like switches from outside or an extension cord or whatever the fuck was around. And so, when I say she'd beat us, I don't mean like she was hitting us with her fist sort of thing, but just like unnecessary, physical…it was just too much, you know? She came at my sister with an ax one time, and she still swears this never happened. We had these decorative axes on the wall and my big sister who is a year and a half older than me, so she was pretty young at the time…My mom takes this ax off the wall and is chasing my sister around the house with this ax. It was fucking crazy…but once again, it was super normal for us to experience that kind of stuff…So while it was normal, I think we knew that it wasn't okay because when they [CPS] did come and ask us questions, it wasn't like we were all like, ‘yeah, well we get beat every night and whatnot,’ you know what I mean? Like, none of that was said. So, I don't know where they got the abuse part of the case, and I don't know
how they figured out the technical reason. And then we all went to foster care and that was...shitty.

May’s first notable experience with the mental health system occurred at age 8 when she saw a therapist upon entering the foster care system. She remembers particularly “hating” that therapy experience. Then, May’s first admission to an IPF occurred at age 11, and she stayed there for two weeks. She was discharged directly back to the same foster home but was moved to a different home shortly thereafter.

Her next notable mental health crisis occurred at age 14 when May attempted suicide. As a result, she was again hospitalized in an IPF. Prior to this suicide attempt, May had been struggling with symptoms of self-harm, depression, and suicidal ideation. She described her memory of the event.

…That was actually my first try with pills…it was maybe like 10 that time of some just really heavy sleep medicine type pills…I was kind of groggy-ish in the morning and my sister had found the bottles. So, my foster mom took me to get my stomach pumped and everything. And I went to a [different treatment center] in [city] for a little bit over a month, I think, so that they could find me placement. And then I got sent to [RTC]…and I was there for 11 months.

May was admitted to an RTC that was structured in many ways like a typical group home. The facility currently has a different name than when May lived there, but she believes it is still housed on the same campus. The facility served adolescents up to age 18-years-old.

There were three cottages when I first went…12 girls per cottage. [Residence type 1] was like the low-level one, we didn't need as much supervision. Then you've got [residence type 2], which is mid, and then [residence type 3], which is, in my words, ‘everyone in
there is freaking crazy.’ So, there were the three ones. When I was there after a while there ended up being…[residence type 4] which was low level. So, I got moved to [residence type 4].

She also clarified that although she stayed at the RTC for 11 months, she only needed approximately four months of the treatment, “…but they couldn't find me a home, so I just stayed until they did find me one.” May portrayed feeling additional frustration with her prolonged admission because she “…never had a behavior,” meaning a behavior that warranted the RTC staff to “clear level” and utilize physical interventions. May later clarified that she was actually physically restrained once by staff and recalled “…it's super clear in my mind…as I'm being restrained, I'm just walking and there's this freaking cow [outside the window]. And I was like ‘what the heck, oh, hey cow,’ it was so close. It was so weird.” She recalled that the reason for her aggressive behavior resulting in physical restraint was related to her felt frustration about being in the RTC longer than necessary. More specifically, May was doing well when compared to her peers.

I just don't like the special treatment for people who were like acting out of line because the people who are acting right are like, ‘okay, well now you're overlooking me for doing what I'm supposed to be doing.’ And I've seen it happen so many times, you know? And then like, ‘okay, well apparently I need to act out and then start acting right, and then you'll give me stuff” and then it's like, that's stupid. I just don't like it…. I did my thing and it's not like I was even trying really hard to follow the rules. It's just something that I did. It was like, okay, cool. But then it was like, I'm still here and nothing's changed. And now I'm seeing everyone else come and leave. And then once again [her peers] ended up getting incentives for acting right for the day and look, they've had behaviors every
fucking day this week…but cool, you go one day without a behavior, that looks so fucking great. Like that's crazy. So yeah, I got pissy and I started acting out and I stopped picking up chores as much. And I lost my leadership status obviously because of the behavior that I had. And then I started to self-harm more at that point too and stopped participating in groups as much. And I just, I don't know. I kinda gave up on the program really.

Other than the one physical restraint, May did not engage in aggressive nor disruptive behavior while at the RTC, and described herself as a child who typically followed rules and expectations, especially when in foster placements. However, she also admitted that toward the end of her admission, she engaged in rule violations with the other adolescents. May admitted that “the first time I huffed was with them [RTC peers] in their room.” She recalled the following story.

[We would] get out whenever the fuck we want. So it's like two o'clock in the morning, we're all supposed to be asleep. Third shift is just chilling. We're outside, like smoking cigarettes and hanging out and talking in a locked facility, you know, like, yeah, we would go up on the roof during groups and stuff or whatever and smoke and like hang out and whatever. And no one knew.

She further described some negative consequences associated with getting to know the other adolescents.

…it could be bad. Cause it's like when you go into prison and you're a little white-collar criminal, you're going to come out a better criminal because now you've got all these other criminals who are telling you better ways to get away with stuff and other things to do.
May also described her admission to the RTC as being more smooth than that for some of her peers because she already “…kind of knew what to expect because of being in so many foster homes and stuff…so it wasn’t a big deal, you know? Like you move your stuff, go to your room, you get a roommate.” May’s sister had also previously lived at the same RTC before May was admitted, so some of May’s peers knew her sister. She described her experience of living with 12 other girls there: “…someone's always on their period, first off, which is annoying. And then on top of that, it's like, everyone's angry. Like they're all so mad, you know, about just life and what's all happened.”

Moreover, May was asked to describe what her experience in the RTC as a child was like, and notably, her initial memories of the RTC were largely negative.

It sucks. It's like so bad. I hated it. For one, there's zero positive things that I learned in treatment. Like there's nothing that I took from treatment except that I learned how to make better than sex cake with the soda. And I thought that was really cool.

Additionally, one of May’s first memories associated with her time at the RTC was her perception of staff members’ poor boundaries with the adolescents living there. During her first week living at the RTC, she recalls overhearing “one staff [who] was sitting on the couch, talking to one of the ladies [residents], about all her favorite alcohols and stuff.” May felt as though a staff member talking about substance use with adolescents who are in a treatment facility was “completely fucking inappropriate,” especially when the adolescents were attending “NA classes” as part of their treatment. May also “dated [her] staff” while in the RTC, whom was at least 9 or 10 her senior. May’s relationship with this staff member was a recurring topic throughout our interviews as the relationship greatly impacted her. May explained:
…she was my primary staff and our primary staff is the only one who gets to take you out on outings alone…Yeah, so we actually started dating while I was still living in the group home… and she's my best friend now, love her to death, but the whole thing was completely inappropriate. We dated for two years. So, like I said, we started in the group home, but we still dated for awhile after the fact.

Some of May’s rule violations were related to her relationship with the staff member, for example, May “snuck [her] phone in there two times actually and got caught both times” to talk with the staff member, whom she described as her girlfriend. May also expressed feeling particularly disappointed in some of the ways her relationship with this staff member impacted her engagement in treatment. For example, May feels as though she “wasn't really focused on my treatment very much, obviously, because of my girlfriend.” She also worried about protecting the staff member from negative consequences associated with others finding out about their relationship. Despite feeling some regret about the relationship, May was also clear that she would not have changed anything because she truly loved and cared for her ex-girlfriend. May does not “feel like she's [staff member] a predator or nothing like that,” stating that “she's my best friend now. So I'm defending her all the way, but she was just not in a good place” at the time of their relationship. In general, May felt as though others were not “paying attention, so it was pretty easy to mess around and sneak around and stuff there without getting caught.” There was one instance in which May was fearful that she and her staff member would be caught.

She [staff member] got in trouble almost once. Cause someone had seen us kissing…but then this one girl, [girl's name], she said she'd seen it too, but…the details didn't match up…so she [staff member] got taken away for a while. Like there was a little mini-
investigation and she couldn't work on [other cottage] anymore. But that lasted like maybe a week or so…So that was scary…We still continued to date after that.

May reflected on her relationship with her staff member stating that “I wouldn't be where I'm at now if I wouldn't have gone through that back then, but it's also like, I feel like I could have been in a better place if I would've not done that.”

Another important experience May had while at the RTC involved her sexuality and experience with religion. May described her mother as “super, crazy religious” and May felt as though the religion that she grew up with before entering foster care was “ruled by fear that if you do this, God will punish you type shit.” She also recalled being taught and subsequently believing that “it was wrong to be gay, like you're going to go to hell” while also clearly knowing since the fourth grade that she “…was more attracted to the girls than I was with the guys.” May described how the RTC offered her a different perspective about sexuality.

…When I went to the group home, I never just was like, ‘yeah, I really liked girls,’ but I think I got more comfortable with it because I mean, mostly everyone at that time is bisexual or lesbian…you're surrounded by girls and everyone's horny. So, I think that's where I got comfortable kind of saying it because up until that point, I was still kind of ashamed of it because I still had background of like, I'm doing something wrong. Not that I really thought I was going to go to hell anymore, but that it was unnatural and whatnot. My mom actually disowned me which fucking sucked…I guess being around a bunch of people who were like, ‘yeah, I'm gay. I like girls, whatever.’ I guess they like gave me that confidence to just be like, ‘yeah, this is what I like.’ So even though I never really actually came out, it was after [the RTC] that I was more vocal. Like if someone would ask me there was never any like, ‘Oh, well I like this boy,’ I would be able to openly be
like, well, ‘yeah, I like girls too.’ And at that time, I only liked girls. I thought I was
lesbian because like I said, boys were kind of cute, but I don't want nothing to do with
you. Which was clearly not true, I've got a whole kid. I am not a lesbian. So [the RTC]
just gave me the confidence to…like, if people don't like it, then that's their situation but I
shouldn't have to hide my sexuality because of other people, including my mom, which
was a huge barrier for me to get over with my mom and stuff cause I wanted so badly to
have a good relationship with her. Cause you know, we were gone out of foster care and I
wanted her to love me. I kind of just withdrew a little bit more and then I was just like,
well, you know, that sucks, but I can't change who I am, and I wouldn't want to because
girls are great.

Another major positive takeaway from her RTC treatment was her felt closeness with the
other adolescents in her cottage. May described that “most of what [she] took away from [the
RTC] was from talking to the girls and just from hearing about their experiences and learning
their coping skills and, you know, just talking to them about their lives.” She fondly recalled:

…the girls there had the biggest impact. I don't know, I just feel like it's so important
that there were all these girls, like around the same age-ish from all these different walks
of life who we all kind of met there on our journey…we were all on the same level. We
came in with whatever was in our past and we started fresh. And I just learned so much
from them.

When getting ready to discharge after 11-months of treatment, May highlighted many
difficulties involving loss of relationships and a difficult school transition. Her felt loss of close
relationships with her peers was especially impactful, throughout both her discharge and the
discharge of others. She recounted that the RTC “…just forced me to be more sociable I guess,
and then I kinda missed it when I left.” May also felt as though the discharge process out of the 
RTC “set you up for failure” because of the stark contrast in structure between the RTC and 
typical discharge placements. May described how she experienced her peers leaving.

…it's like, all you have are the people that are in there with you. So you try to build this 
connection with someone, fucking anyone, really. And then if that person is taken away 
from you, then it's like a whole ‘nother betrayal and, you know, [its] just hard to handle.

She believes “…it would help to slowly pull away” from relationships formed at the RTC 
prior to discharge, describing that a “sudden” discharge “fricking hurts a little bit.” She also 
struggled academically after her RTC discharge and described her adjustment transitioning from 
the RTC schooling to public school academics.

…[At the RTC] school was never challenging at all. And it used to be my jam…So I had 
this math teacher [at the RTC] who was horrible…but I was the highest math level that 
they had [at the RTC]. So they had to buy a new book for me…a pre-calc book cause I 
wasn't gonna repeat a math class, you know? But my teacher (and I don't understand [the 
math], obviously, it's a new type of math)...so [my teacher is] trying to explain it to me 
and I'm like, ‘okay, this is not making any sense, I don't understand it.’ And then I'd be 
like, ‘okay, well I solve this problem this way, but this is not the answer, so like help me 
solve it the right way anyway.’ So he would never get the answer right either. And he 
would always be like, ‘sometimes the back of the book is wrong.’ Which like, maybe 
there's a fluke once or twice, every couple of books, you know what I mean? But 
anyways, I passed with an A because he didn't know how to teach me. So when I went 
back [to] actual high school, I was in calc because I have too much pride to be like ‘hey, I 
should probably take pre-calc again.’ And I was pretty lost. So that sucked…that part
sucks, just school [in the RTC] not being challenging at all…I think they kind of thought we'd be stupid.

May provided another example of the rudimentary nature of her education while in the RTC.

…Our reading class consisted of our teacher reading us a book and we sat and listened…She’d sit there and she’d read and it just sucked…and then I think there were some multiple-choice questions about what's going on in the book and it's like, this is elementary. We’re all teenagers, we're all middle school, high school at this point…It makes you feel kind of small…I think we can do a little bit more…we can read our own books.

She also described that prior to the RTC:

…School made me feel better. So to take away that, for me, it was kind of crap because I didn't know where to go, where I belong, because I was always good in school. And then when you don't have to try to be good in school or when everyone's good in school, anyone who actually puts forth any effort, it just was like, it wasn't my thing anymore, I guess…So I don't know why they did it, if they thought we were stupid, if they didn't want to put too much pressure, too much stress on us…But I think that you have to take into account that we're all at different levels and then like plan accordingly when it comes to our curriculum.

May also described how her educational experience at the RTC impacted her self-esteem and confidence once back in her public school, and how her race impacted her felt pressure to perform well.
…Another part of it is like me being black and the only black one in my math class…I just felt like there was this, like I had to stick it out and finish and get good grades because I just wanted them to think (obviously I don't think I'm stupid)…I just didn't want them to think less of me…which is a stupid thing…So…in like this all black school and all the honors classes, there's just like mostly white people…So I feel like I've got to do great, you know, to just be like, ‘yeah, we can do it too’…it just sucked.

Although May does not recall engaging in any community-based programs post-discharge, she continued to see the same therapist who was the “…best therapist I've ever had in my whole life” and was later diagnosed with Bipolar Disorder as an adult. May attributes her openness to seeking therapy to the therapist she had while in the RTC, describing “…she's what made me more receptive to therapy and she's amazing. I absolutely love her.”

After 11 months in the RTC, at age 15, May discharged to a foster home. She continued dating her girlfriend (RTC staff member) for at least one-year post-discharge and graduated from high school early, at age 16. May then attended college and moved into college housing. Unfortunately, she failed out of college on two different occasions largely due to her young age and substance use. May then attempted suicide at age 17 by taking 117 pills, which required hospitalization in an IPF for two weeks. After her first college failure, she found out that the Dean of her university had submitted an academic appeal on her behalf. Unfortunately, May never received paperwork which required her signature to re-enroll. As a result, May was officially expelled from college her sophomore year at 17-years-old. May then returned to a foster care placement and later re-enrolled at a different university. During her second attempt at completing college, May “learned about alcohol” and “became an alcoholic.” She was kicked out of the college dorms and moved in with her boyfriend at the time, who is her son’s father.
At 19-years-old, May aged out of the foster care system. She then gave birth to her son at 20-years-old. She described her pregnancy as a complete surprise because the father of her son is paralyzed and was told that he was unable to conceive. Since her son’s birth, May and her son’s father have worked out a positive co-parenting relationship and she described initially struggling to balance a full-time job, parenting, and attending school. She is currently in college again and aspires to become an accountant, and later attend and complete law school so she can work as a guardian ad litem within the foster care system. Notably, May was placed in 12 different foster homes since the time she entered foster care at age 8 through the time she aged out of foster care at age 19. Now, at age 25, May feels optimistic about how she is managing her life and responsibilities.

When reflecting upon her experience in the RTC, May described feeling more “free” and confident in exploring relationships after the RTC.

I think it kind of made me want to go out and like explore different friendships, which was still very hard for me coming out and stuff. But I think that helped me try to be more sociable. I'm still not very sociable, but I would like to think I'm a lot better than I was when I was 14.

She also continues to utilize skills that she learned in the RTC related to organization and structure. May described how she has carried over such skills into her adult life.

…sometimes when I'm getting overwhelmed and stuff, I'll make schedules out or, you know, write stuff down. I don't know it makes me feel better. So I think that was something, cause I learned that there. I think that was positive, it was good. And I still incorporate it in my life…some people think it's boring, but still it's nice to be able to depend on that structure.
Additionally, May described ways she gained empathy and understanding of mental health difficulties as a result of her time in the RTC. She paralleled her experience of self-harm while in RTC with how she responds to self-harm as an adult.

…It’s easier for me to recognize a cry for help…And I'm actually okay with talking to people about it…we were at Walmart and there was this person and she had pretty deep cuts all up and down her arm, but she had on a sweatshirt…and had the sweatshirt completely rolled up, you know, so that you could see and stuff. And so, what we used to hear [in the RTC], is it's just like, ‘Oh, they're just like doing it for attention.’ And you know, ‘they just want people to feel sorry, feel bad or whatever.’ And I think it's crazy cause even if someone is doing that for attention, don't you think they need some help? Cause why would you put yourself through that sort of pain only to get noticed? You know what I mean? So anyways…we were in Walmart for a very long time…I had talked to her about [the cuts], and then she just like spilled and it was cool. I felt good…thanks to [RTC], I think I was able to approach the situation in a way that was helpful, hopefully. I felt like I was more equipped to be able to let her talk about it I guess. I felt like I could come from a place of no judgment and, honestly just kind of curiosity…I think I've learned that throughout all the groups and stuff at [the RTC], because there was a lot of talk about self-harm and why we do it and all these different things to help us stop, which I will say…the rubber band trick seems so stupid, but I think it was one of the most helpful ways to stop…which I told her and stuff too. And so she said she'd try it.

May described that while in the RTC, she also learned how powerful rigorous exercise can be in modulating her mood, stating that she “felt so much better” after exercise. May also
described that since residing in the RTC, she has become “…much more blunt and just like no bullshit…because it's like, I don't want to play, I don't play games. I don't know, it's stupid to me.”

Upon identifying impactful experiences in her life, May feels that the impact of her experiences are “…half and half with foster care and [RTC], as far as how it's impacted me as who I am now…there was just so much that went on [at the RTC]….and it was only 11 months, but it was dense.” She also described how her perception of and attitude about the RTC treatment has changed over time.

I didn't want to be there because I didn't feel like I wasn't getting anything out of it. I didn't feel like they would be able to help me with my issues and whatnot. I didn't think I had that many issues also…obviously my perspective on it changed. I think that I got a lot more help in [RTC Program] than I thought that I did at the time, and even like a little bit afterwards. I was like, ‘well, you know it didn't help me,’ or ‘I made all these changes myself.’ But a lot of changes that happened did happen to me because of [RTC Program]. So I think that in a weird kind of way, I'm appreciative for having gone there just because…I really cherish the experiences that I had with the girls there. Where else do you get that kind of interaction?…So I definitely did a 180 because, like I said in the beginning ‘I'm getting nothing out of it and basically what I was better than that place.’ And like, ‘I didn't need to be there.’ And now I can recognize that I learned a lot while I was there. And even my personality still reflects things that I took from [RTC Program]. So yeah, full 180.

Overall, I greatly appreciated May’s participation in the study as she presented a candid picture of her experience in the RTC as child, and how her life has unfolded since. Although she
was initially certain that she gained nothing positive from her time in the RTC, she uncovered positive memories throughout our interviews. Upon reflection of her participation in the study, she gave helpful feedback to improve the research process in the future. She described her experience.

  It's been really cool looking back cause in the beginning I was like, ‘this isn’t going to do anything.’ But the more I talk over it…it's nice to have thought about it…It's just cool looking back and being able to talk through it all and reminisce, I guess…and [I] realized how much I've really been affected by it, you know? I think it was good.

  Personally, May had an impact on me and taught me a lot by the shear nature of her engagement in the study. I was continually impressed by her resilience, openness, perseverance, and kindness. I picture May as a staunch advocate for children who may have had similar experiences as her and recognize the positive impact she has already had on the world. Her parting hope was that “something can change because right now it's not going super well.” I have confidence that May’s participation in this study will enact change to the structure of RTCs for children, or at a minimum highlight important questions about RTC treatments that cannot be ignored. I have no doubt that May will meet her goals and I will be rooting for her from afar.

*Eve*

  Eve is a 20-year-old white, cisgender, heterosexual woman who uses she/her/hers pronouns. She was recruited for participation in the study by a colleague conducting research with a similar population. Eve participated in five, one-hour Zoom interviews spanning across five weeks in December 2020 and January 2021. One of our meetings even occurred on New Year’s Day 2021, which I feel speaks to Eve’s commitment to the study. During each of our interviews, Eve was in her bedroom at her maternal aunt’s home, where she lived full-time in a
Southern state. I remember that Eve’s background on Zoom depicted lights strung across her wall above her bed. I was in my apartment in downtown Minneapolis, Minnesota for all interviews. Eve struck me as very genuine and seemed to be quite open and honest throughout our interview process. She demonstrated vulnerability during the interviews and was at times tearful when telling her story. Eve allowed me to enter her world and was patient with me during my attempts to understand her perceptions about her own life. Her childhood was traumatic, and her stories roped me in. She also narrated the incredible ways that she is unique and successful, especially upon consideration of her upbringing. Eve was eager to share with me and we did not often engage in small talk, instead quickly engaged in meaningful conversation. She also perfectly described my inspiration for this study “…a lot of us I've noticed don't...Too many of us don't get better...And you don't know who that's going to be.”

When I met Eve, she was five-months pregnant with her first child and had recently started a new job working at a luxury senior living facility that provided memory care. Eve was also completing educational training at the time we met, with the future goal to become a nurse and/or an EMT. She was dealing with several significant life stressors at the time including filing for bankruptcy and following through with consequences associated with a recent DUI charge (substance abuse treatment, probation, lack of a vehicle, etc.). Much of her story speaks for itself and I chose to rely heavily on her words in this text, as well as the order in which she revealed information. Although she admitted that her memories are not linear, I felt as though she told her story in a coherent manner that allowed me to garner a genuine understanding about aspects her life. Eve opened by describing her childhood with her mother and stepfather.

My stepfather was an extremely abusive man…he came into our lives when I was five. He would hurt me. He would hurt my mom. And my mom is an interesting person, she
likes abuse like that. She seeks it out and I would say do anything to have that in her life…I never said anything about it until it was brought to me. I thought it was normal for pretty much my whole life. One day I went to school and they pulled me into the counselor's office and asked me about some bruises that were on my body. And I didn't say anything, I didn't speak, I just kind of stared at them. Then after that, the police showed up at our house that same night and wanted to talk to me and they talked to me in my room and at that point I did tell them, you know, what was happening. And I opened up to them and I told them how my stepdad was scary and how he would hurt me and my mom. And then after that, the police went and they talked to both of them. And my mom said that I was lying, that none of that ever happened and that he would never hurt either of us. And, um, of course he said that I was crazy too, because why would he openly admit something like that? And then after that happened, my stepdad was so angry with me. I didn't even do anything, but he was so angry at the situation, and me I guess, that he—there's this road in between [Town, State] and [City, State], it's just a straight shot to [Town]. He dropped me off in the middle of that road and told me to walk home. And at that point I learned how to run away. So, I started to run away…and when I say run away, I literally, most of the time would just go in the backyard, but they didn't know that. I got into trouble for that with the cops because they always called the cops on me of every time I'd run away. And they usually had to search for a few hours and then I would usually just go home at that point if so, but eventually they started taking me to the hospital.

After multiple hospitalizations at a short-term IPF because of her running away behavior, Eve’s mother arranged for Eve’s admission to an RTC. Eve recalled that “…at that point my
mom disappeared. She didn't come visit me at the hospital. She didn't attend any of my therapy sessions. She just kinda went away.” Eve admitted directly to the RTC from the IPF and ended up living at the RTC for approximately two and a half years, from age 8 to age 11. She recalled that her mother “…was [at the RTC] like two times. I remember one time she brought me lunch and the second time was when she signed her rights away.” Eve’s RTC therapist had also given her mother’s visitation privileges to Eve’s aunt, because Eve’s mother never showed up. Eve described her perspective about her admission.

I firmly believe that nothing was wrong with me besides the fact that I was scared because I was in an abusive house, and I was terrified of my stepdad. I don't really think there was…need to live in a residential facility…I always just wanted to play with my friends. I'd literally ride my bike and go to school. And that was it. I wasn't really a troubled kid.

However, Eve’s mother portrayed her as “crazy” and denied Eve’s abuse allegations. Eve described how her mother’s behavior impacted her.

…[I] thought for a long time that I really was crazy cause my mom, she'd tell me all the time, ‘you're crazy [Eve].’ Like, ‘something's wrong with you [Eve].’ And she'd just drill that into my head. And my therapist, I told you [Name], he was my therapist the whole time I was [at the RTC]. And it didn't take long for them to realize that my mom was lying about some things…they didn't necessarily know what she was lying about, but they knew something was wrong. Cause she never came to visitations. She never came to therapy. She never called my therapist. She was never in contact with anyone…My therapist would always try to tell me ‘No, [Eve], you're not crazy.’ Like, he hated that my mom would tell me that, because I wasn't crazy. And he said, ‘No, [Eve], there's
nothing wrong with you.’ He said, ‘you've been through a lot, and you don't know how to process it.’…I didn't talk much as a kid, especially after the police, when I told them everything and then they just disappeared.

The RTC where Eve lived had a large campus and consisted of multiple, family style homes. At first, Eve described struggling behaviorally, especially since picking up on negative behaviors from other children in the IPF. She recalled having a friend at the RTC with whom she got into trouble. The RTC program was based upon a behaviorally oriented level system in which kids could “level up” based upon their behavior and progress toward their goals. One of Eve’s significant memories was her felt sense that she was “different.” She recalled that she even felt different during the weekly church service and remembered the pastor “…saying things that just, made it obvious that we were different…I don't remember exactly what he said, I just remember feeling like ‘I really am different. Even he knows it and I don't even know who he is.’”

Other memories associated with her RTC treatment included her diagnoses and her multiple trials of psychotropic medication. She recalled the RTC staff/providers attempting to diagnose her.

Because my mom has borderline personality disorder, they [RTC providers] were trying to put that on me and I don't have that at all. I was eight-years-old when I went in, and I didn't need someone to fix me. I needed to be a kid because that's not something I have had. I mean, they're so quick to diagnose, especially youth because they want to fix the behavior problem right away. But…I would beg to say at least half the time the behavior problems are because they're kids, they're scared, they're lost, they don't understand
what's happening. And that was something even I had. I didn't know what the heck was going on. I was too young, too little to even grasp what was happening.

Eve described her experience being put on psychotropic medication while in the RTC.

They put me on Risperdal, but I was allergic to that, so I didn't take it anymore. But Abilify is a pretty well-known anti-psychotic, and I was on that for years. When before I went to the residential treatment facility, I wasn't on that or any other med for that matter. And I was a super skinny, super healthy kid. And when I say healthy, I mean like super healthy, like I was pretty much, I was super active…I would ride my bike around the neighborhood a lot and play with my friends, and that was normal. Like, I had normal kid behaviors. Soon as they put me on Abilify…I just don't feel like it even really helped me with my behavior problem because I still had [negative behaviors] all the time. And I also gained a bunch of weight. And I went from a really skinny like twig child, but healthy child, and I gained so much weight. I was a huge child after that. As soon as I was on meds, I blew up like a balloon…I was taking meds three, four times a day, and that was normal for anybody there. I'm talking about a cup of meds. I don't know, to me, that just seems crazy. That seems absolutely bananas because who needs to be medicated 24 hours a day? Especially when their brain is still developing?

She also remembers comforting interactions with RTC staff.

…A few staff members were pretty good about making me feel…like I wasn't so bad. There [were] a couple people who would do our hair on the weekends when we had extra time and they would help brush our hair just literally for comfort. That is what meant a lot to me. Or they'd color with us. And when I was a kid, I loved to color and I was terrible at it, but I absolutely loved it. And so, they'd go out of their way to print those for
us so that we could color…But they made me feel like sometimes that it was going to be okay.

After a year and a half, Eve had done well with the program and had “leveled up” enough to be placed in a transitional program which was housed within the same agency, yet was not technically considered an RTC. She recalled:

I was only [in the transitional program] for at most a month and then I went back to [the RTC] because I started to run away again, and I was really suicidal at the time. I really honestly wanted to die and that's why I would run away so much. Sometimes I would run out into traffic to try and get hit by a car while I was there. I was really self-injurious. I would scratch my arms till they bled, or I'd try to stab myself with sharp stuff. That’s why they [the RTC] ended up taking me back.

When she returned to the RTC the second time, Eve recalled how her treatment was different.

…They came at it with a different approach than they did the first time. Instead of assuming I was crazy and treating me as such and medicating me and whatnot, they started to try to work with me about like…being a kid…they started to treat me like I was a kid a little bit more. And it wasn't so structured. I did really well with structure, so I always had a good amount of structure while I was there, that's what I responded the best to, but they allowed me a little bit more flexibility. Maybe they started to understand how I responded to things and just catered to that. The second time I was there, I did really good right out the gate. I was phenomenal and I leveled up really fast—like as fast as you could possibly level up. And I responded really well to therapy. I don't remember exactly what they did different to make it that much better, it was just a lot, a lot better.
She recounted some of the ways her RTC programming helped her succeed the second time.

I knew exactly what to expect…I also have always been one that has responded better to structure, having a structured schedule, even in my life now it's still really helpful to have. The first time I was there, I was learning their structure, how they do things, and it was changing a lot. The second time I was there, even though I was only gone for maybe a month, it had changed…[but] most of the staff that were there were still there the second time, which was a good consistency factor. And that helped contribute to my better behaviors, they also knew me. So, they knew my behavioral problems. They knew who to keep me away from. They knew already what I responded well to, they knew if you gave me a coloring picture or if you gave me extra schoolwork that I would have a better day. So, I feel like part of it was the fact that they already knew me and they already knew what I responded to and what I did well with. But then also…I wasn't as confused. I knew what was going on every day and I knew what to expect, which gave me less anxiety…I also knew that there were certain things I couldn't get away with. So, you know, I didn't even try.

Eve’s attitude about treatment was also different the second time around.

I didn't want to be there at that point. At first, I didn't really care. I didn't know what was going on. I didn't know any better. But the second time I was there, I knew I didn't want to be there. And I knew I had to do good to leave. And so, I just didn't know what, where I would go at first.
It was at this point that Eve remembers staff talking with her about where she would go after the RTC. She remembers that her therapist told her: “…your mom doesn’t want you.” Foster care became her only option.

…CPS or DHS had opened up a case against…my stepdad…he actually was going to get sentenced and go to jail for hurting me. I don't know [about] my mom, but for sure me. And they said that if they do that, that [my mom] would also be convicted for neglect and not reporting [the abuse] because she obviously knew about it. So she was also facing jail time, but they gave her a plea deal, which was: if she signed her rights away, she wouldn't have to go to jail. Her option was to either kick him [stepdad] out and proceed with the prosecution process, or she could sign her rights away and face no penalties. And she chose to sign her rights away. And that was the last time I remember seeing her, was in my therapist's office…she didn't even say anything to me…she didn't cry. She didn't look tore up. She just kind of, she looked normal to me. I guess she wasn't upset or anything…I just saw her, and she left, and then I went to foster care.

Eve described her experience meeting prospective foster parents while in the RTC, as her social worker was looking for a discharge placement. After meeting the couple that became her foster parents, Eve was discharged to their care within approximately two weeks. Overall, Eve felt as though she “…got lucky in the sense that I got really good foster parents and I had a really good therapist…So, it made the transition really smooth for the most part…That was probably one of the smoothest transitions.”

Eve described her new home as “…hands down the best foster home I’ve ever been in.” She went on to describe her foster parents as “…super essential to my desire to do better because before I was with them, I really didn't have the desire to be better. I was totally okay with being a
jerk to everyone and didn't really care.” She recalls the structure in her foster home having been helpful and fondly remembered participating in STEM activities through a girl’s community group. She described her foster parents’ unwavering support.

I still had a lot of issues with the self-harm and the suicidal ideations. They always took me back every time the police would pick me up [after running away]...I watched the cops ask [my foster dad] one time if they even wanted to take me back. And every single time they said yes...they always took me back.

Eve also attributes many essential and positive learned behaviors to her foster parents.

They're the ones who taught me how to vacuum and how to brush my teeth the right way. They taught me how to wash my hair by myself. And they taught me lot of life skills, I guess. They didn't really teach me so much as far as being a kid, but they allowed me to be a kid when I wanted to be. They let me go play with my friend, the neighbor friends. But they also taught me compassion, they taught me what it's like to be loved.

Eve also had a “really good therapist” after her RTC discharge and recalled that she was “probably the first person to treat me like a kid.” Eve continued to experience suicidal ideation post-discharge and was readmitted to an IPF on multiple occasions while residing with her foster parents. After approximately two years, Eve’s foster parents tried to adopt her, however, Department of Human Services (DHS) placed Eve with her biological father instead.

DHS sought him [Eve’s father] out because he was the only one with custody. And they [DHS] say that they were legally required to look for him before I could go for adoption because my foster parents were going to adopt me if he didn't want me. But he did. I was like his trophy kid, and he was perfect for real. Like the whole time we talked, he was like the perfect dad. He gave me everything I wanted. He always told me how proud of
me was, he'd go to my school stuff. And then as soon as he got full custody of me and
DHS wasn't in the picture anymore, he flipped like a switch the same day. He started
making me lie to my therapist and then eventually he just took me out of therapy
altogether and he started to hurt me a lot. And then after he would hurt me, he would say
like, ‘Oh, I'm so sorry. I'll never do it again. I love you so much. Don't say
anything.’ …Sometimes he would get ice cream after, so I would calm down if I was
super upset. And that was just like a cycle almost…just happened all the time for awhile.

Prior to being placed with her father, Eve had little interaction and knowledge about him,
other than being told by her mother to “…watch out for people watching me, which she was
referring to my dad.” As a young child, Eve also remembered “…seeing him a couple of times
in his car, just following me around.” She met her father for the first time at age seven.

…He wanted me to spend the night at his apartment and I ended up staying at his
apartment, which was a homeless shelter, for a night. And he gave me a giant duffel bag
of presents. And he gave me some chocolate milk. Then I fell asleep, and I don't
remember waking up until the next day. And when my mom picked me up…she took me
to this place…it was a place where you report sexual abuse for a kid.

Eve did not recall what happened while staying with her father, however, she did not see
him again until she was placed in his care at age 13, after her foster parents attempted to adopt
her. While in her father’s care as an adolescent, Eve experienced severe physical and
psychological abuse by him. She described that her father “…makes [her] stepdad look like a
saint.” For example, Eve described that her father “…put [his] fist in my mouth and split my lips
open,” and “…cut the breaks to my bike and I shattered my ankle.” Eve also remembered that
her father “…put a knife to me…and killed my hamster in front of me.” She described him as a
“textbook psychopath” stating that “…he would be one of those people who would like murder someone if he just snapped one day.”

Eve also talked about her father’s ability to manipulate her and other people, stating that he “…scares me because of how many times he's either convinced me [of] something that I know is not okay…Or that something that has literally just happened did not just happen, like I'm crazy.” While living with her father, Eve also confirmed for herself that he had sexually abused her at age seven. She based this upon his behavior and his bragging about lying to DHS about the suspected sexual abuse. Eve and her father eventually moved in with Eve’s older paternal half-sister, who began to witness the abuse and began to try an protect Eve. Eve recounted “[my sister] started to see it. Like one time [my father] was going to punch me in the face for falling asleep on the couch. And [my sister] got in between us and she told him to hit her instead.”

While in her father’s care, Eve was hospitalized at least once in an IPF, and after awhile, her father “…went off the grid.” Eve was then cared for by her older paternal half-sister for approximately 3 months. Eve was hospitalized in an IPF at least three times while in the care of her sister and struggled to attend school, despite loving school. Eve described the timeline of placements and how much her mental health deteriorated during this time.

…When I lived with my sister…I had really bad, really, really bad PTSD. And that's probably the worst it's ever been in my entire life…even compared to residential. Like it was awful. So, it was residential, two years of foster care, in and out of hospitals because I was very suicidal and I hurt myself a lot. I had a lot of self-harm tendencies. There was my dad who was very abusive and did terrible things to me. And then I lived with my sister and my PTSD was literally the worst. Not just the worst for me, but I've ever seen. I literally had panic attacks every waking moment of every day. If I wasn't asleep, I was
hysterical until I would literally have a panic attack so extreme and severe, and I would cry and I would dehydrate myself and I'd hyperventilate until my breathing was so shallow, I would literally pass out…That was for like probably six or seven months, just every single day. It was the worst I've ever had as far as issues. And before [my Dad] disappeared, he threatened to kill me and take me off the grid. And so not only did I have all the other years of trauma and the fact that he had done terrible things to me, but he said that too. And then he disappeared. So then I was panicked and worried and paranoid because nobody knew where he was, but I knew he was looking for me and that was scary. So I was incoherent for the most part. Like you could talk to me, but I wasn't listening. I had such severe panic attacks and flashbacks…my flashbacks were so consuming.

When Eve was either 15 or 16-years-old, her father was arrested. She transitioned from living with her paternal half-sister to living with her maternal aunt for a duration of 7 months. During this time, Eve, her half-sister, and Eve’s niece all had a restraining order against Eve’s father. As a result, Eve was officially a ward of the state again. Eve’s placement with her aunt did not last long due to Eve’s poor mental health associated with the trauma she endured. Eve’s father had also broken the restraining order on at least one occasion and contacted Eve saying that “…he was going to kill me, and he was going to find me, and he'd never stopped looking for me, like all really scary things…I was terrified.” She admitted that her mental health was so poor at this time that she “…probably should have gone back to a residential treatment facility.”

At age 16, Eve also stopped taking her medications “cold turkey” because she felt as though she had no awareness about which medications did what, and whether any of them were
helpful. She described her experience with stopping the medication and focusing on living a healthy lifestyle.

I can tell you from my experience, the way I felt on eight different medications a day versus at first no meds and living a healthier lifestyle does not compare. When I was on all the meds, I felt like a zombie, I felt emotionless, I felt like not even a person…But when I was living a healthier lifestyle, I was genuinely happy. Like, yeah, I had bad days, but so does everyone, that's normal. And it's almost like, I feel like it should be more normalized for people with mental health problems, even though our bad days are a little bit worse than most people, bad days are still going to happen, even if you're on meds.

Eve explained that the foster care system was attempting to give her more stability at this time and prevent her from moving around more than she had thus far. As a result, it was difficult to find a placement for Eve in the same city where she was residing. Thus, Eve described officially becoming homeless because she was moving between “temporary other homes,” which were various homes of teachers from her school. She bounced around between teachers over a period of 3 months before being placed in a new foster home. She described the foster father in this home as “fresh out of prison” and as “mean” and “scary.” Eve did not feel safe in this new foster home, therefore, her social worker approved for Eve to live with a coworker for approximately five months. After that, Eve was placed in a supervised apartment living (SAL) until she aged out of the foster care system at 19-years-old. She proudly reported that she graduated high school with a 3.9 grade point average (GPA).

Since graduating and ageing out of the foster care system, Eve described how she became involved in unhealthy adult relationships. Notably, Eve attributes her social difficulties as an adult with her experience in the RTC as a child.
The biggest thing that I can say that I feel like [the RTC] affected was my social skills, or lack thereof. I struggle a lot to make friends. I have one friend right now and we're best friends. We have a really good, strong relationship, but I just, not only do I suck at making friends, but because of the fact that I relate most to people like me, I have a tendency to make poor friends, not good for my life, friends, if that makes sense. And a lot of people judge me for that…my family… and therapists do too, for some reason. And they warn me all the time. They're like, ‘just because of the amount of trauma in your life and whatever else, you're at risk of developing those same relationships in your future and you have to be careful about that so that doesn't become a problem for you.’ It is a problem, it's hard, but it's not like when I walk up to someone I know that they make poor, terrible life choices. And I'm such a caring and compassionate person that even when I find people who do, it's really hard for me to walk away from them and be like, ‘I can't be around you because it was bad for me.’ Because deep down all those people who are making those bad choices, they're not necessarily bad people. They're just people who are struggling with whatever. And that's why it's hard for me to walk away.

Eve also described how she gained empathy and compassion for people who may be struggling, and how she was allured into her relationship with her unborn child’s father.

I don't see why people should be shunned or something like that because I was once that same version. And if somebody would've walked away from me, it would have crushed me at any point in my life. And my son's father is a perfect example of a relationship I should not have ever gotten into. Unfortunately.

Eve described many ways her relationship with her child’s father is unhealthy and contentious, largely built upon drinking alcohol. Moreover, Eve has been the victim of assault by
her child’s father, which was an incident that ended their relationship. Eve demonstrated significant desire and ambition to better her life and provide her child with a good life.

I’ve worked so hard since I found out I was pregnant… to fix everything I can for him [Eve’s unborn son] so that he can have a good life. That's why I'm spending so much money that I don't have on school so that I can get a good enough job where he can have anything he needs and more, and we'll still have a roof over our heads.

She also reiterated how and why she feels as though she is a unique and abnormal case. If I free my mind of the statistics for people who aged out of foster care or spent their life in congregate care, or foster care, or just in abusive homes and they stayed there their whole life and they never really got free from that. When I think about the statistics for that compared to if I got rid of all of that and I just thought about my parents, my biological mom and my biological father, I mean, it's not a very promising future either. And that's why I really feel like I don't know how I got so lucky or why I’m so determined to not give up, I guess.

As an adult, Eve has been diagnosed with PTSD, Bipolar Disorder, and Generalized Anxiety Disorder (GAD). She stated that her previous diagnosis of Borderline Personality Disorder was not carried over into adulthood. Eve continues to learn about mental health and ways to best manage her condition, especially while pregnant. She was open with me about when she was experiencing a “bad day,” and was vulnerable and honest about the need to accept that she will struggle sometimes. She feels that in many ways, experiencing significant trauma and mental health difficulties in childhood has helped her become more prepared to handle mental health difficulties as an adult.
It's a blessing and a curse because it sucks that I had to go through it at such a young age and it made me have to grow up a little faster. But at the same time, I'm not making this mistake at 30-years-old when I can go to prison for making that mistake. And so that I'm grateful for...now as an adult, even if I went through it right now, I couldn't take the time, especially because now that I'm about to have a kid, I have to worry about work and I have a million bills of my own to pay for. That was the time [i.e., childhood] really to make those mistakes and figure it out...I feel like I've learned how to navigate better...I may not always know what to do, what the right thing to do is, but I know what not to do...I know what not to do as a parent.

One of Eve’s major takeaways from her experience in the RTC included her opportunity to live with her foster parents, with whom she still keeps in touch.

...[The RTC] led me to good things like my foster parents, for example...If I didn't go [to the RTC], I probably wouldn't have ever been in that home, which changed my life a lot...They showed a lot of compassion and I think it's really cool...I still talk to them. My foster dad, he’s actually going through a really hard time in his life and hearing from the people that he used to take care of, like me, makes him feel better because he's been kind of depressed. And so when he hears good things from us, it makes him feel better. And I've heard it from his daughter, from his wife, from him. And he doesn't talk much about his feelings probably because he's a dude. But like, they tell me all the time how, you know, reaching out and telling them good stories and stuff really helps. Then I feel like it kind of makes me happy because then it's kind of like, they took care of me for so long and they really changed my life. It makes me feel really happy that maybe, not to the same level or [in] the same way, but I get to kind of help him too.
Eve also described what stands out to her when reflecting on her childhood. The foster home...when someone asks me about my childhood, that's the first thing that comes to my head. And I know it's not much for a childhood if you want to call it that. But I mean, that's what I think of because it's just prominent in my mind. When I was in the abusive situations...it just seems much smaller in comparison...It just seems like my memories are a little lesser. I remember the abuse. I barely remember going to school. I remember I had one friend. I had a couple of friends that I'd walk home from school with every day. I remember that. And I remember my best friend. His name was [name] and he was my neighbor. And well, other than that, I don't remember much. Everything from the residential treatment facility, I would say almost everything is very prominent in my mind.

In general, Eve feels as though her time in the RTC has given her perspective and opportunity to change aspects of her life as she has gotten older. She wishes that she took treatment more seriously at the time and regrets having been a “jerk” to some of the staff members, however, she also feels as though her treatment altered her life in a positive way. She described that “…it's hard for me to say that I would have rather not been at the residential treatment just because it led to good things.”

What I will always remember about Eve is her incredible resilience, determination, and perseverance. Despite the horrific and chronic trauma that she endured at a young age, Eve is kind, responsible, open, and honest. She cares for others’ basic needs despite not having had her own met for most of her life. I have no doubt that Eve will prosper as a mother to her son and will continue creating good in the world through her education, work, and relationships. She now has the space to grow, and she has the ambition and determination to do so.
Summary of the Narratives

In sum, the participant narratives are powerful descriptions of the participants’ lived experiences. Although narratives are inherently incomplete, my hope is that the telling of their stories helps inform the identified topic and fosters understanding about what it is like to be a child transitioning out of an RTC. I appreciated how participants described their experiences in their own way, and that they trusted me to synthesize and present their stories in this document. There is an innumerable number of ways to narrate these experiences, and I hope that this presentation of the narratives provides a useful contribution to our current knowledge base.

Themes Across Participants

Five themes associated with the data were identified and are presented below: learned and used coping skills, changed opinion about mental health treatment across time, increased understanding and awareness of mental health, developed and maintained impactful relationships, and experienced difficult transition from the RTC. In total, there were 54 codes generated from the data. Themes were then generated from 25 identified codes. Associated codes and themes can be found in the Codebook located in Appendix B. The codes were grouped into categories with the intent to answer research question three. There was no repetition in the use of codes as they each fit cleanly within one theme. Much of the content presented in the narratives also emerged throughout the coding process, indicating patterns across participants. The code book consisting of the themes and associated codes can be found in Appendix B.

Learned and Used Coping Skills

This theme was generated from participant descriptions about the types of skills that participants learned while at the RTC, and how they utilized such skills post-discharge, and into adulthood. The following four codes comprise this theme: learned strategy/habits,
organization/structure/strict rules, social skills, and positive coping skills. Common skills that
participants described learning while in the RTC include the importance structure and
organization, the formation of social skills, benefits of rigorous exercise and healthy lifestyle,
and the utility of DBT skills. At times, participants talked about learning maladaptive coping
skills while in the RTC, however, learned positive coping skills is what comprises this theme.

Fred and May talked explicitly about how they translated the structure of the RTC to their
life outside of treatment. For example, Fred described how he utilizes a life coach as an adult to
help him stay organized. He utilizes a day planner, and proactively identifies periods of time
each day to devote to various tasks such as schoolwork, laundry, leisure, etc. Most of the
structure he has created in his adult life stems from his time in the RTC because he came to rely
on the schedule, which helped him regulate his mental health. He continued creating structure in
his life after his discharge and will create additional structure when feeling overwhelmed as an
adult. May also described her tendency to make lists and strictly plan out her day, particularly
when her mood is less stable. When feeling less stable, she described planning out each hour of
her day so that she can attend to her responsibilities associated with school, work, and parenting.
She also schedules in time to relax, watch television, and engage in self-care. Moreover, when
cleaning, May creates lists of tasks that she wants to complete, a skill she learned while in the
RTC.

Participants also identified their formation of social skills while in the RTC. Although
each participant talked about social interactions while at the RTC in some capacity, some
described learning positive social skills and some described learning maladaptive ways of
engaging socially. The social skills that comprised this code and subsequent theme are
considered positive coping skills. May, Eve, and Jill described how they developed adaptive
ways of interacting with others. For example, May talked extensively about her interactions and bonds with the other girls in the RTC. She described having the opportunity to engage in meaningful conversations and subsequently increased her confidence in social situations. Eve also described how she formed relationships with RTC staff members and her therapist, and how such relationships taught her to feel safe and trust others with greater ease. Jill described how she learned to be serious about some of her struggles while in the RTC. She learned that opening up to others, especially in group therapy, enhanced her treatment and personal growth.

Other positive coping skills described by participants included benefits of rigorous exercise and a healthy lifestyle, and DBT skills. Fred, May, and Eve all described engaging in rigorous exercise while at the RTC, and how doing so improved their mood. Fred moved furniture in the living room of his RTC unit and engaging in workout videos. He continues to engage in workout videos with his fiancée in their apartment. May also described engaging in rigorous workout videos with her peers at the RTC. She stated that exercise significantly reduced her desire to self-harm. Although May does not currently engage in regular exercise, she knows that doing so would improve her mental health because exercise helped her immensely while in the RTC. Eve began to exercise rigorously after her time in the RTC as an alternative to taking multiple psychotropic medications that were started when she was in the RTC. She believes living a healthy lifestyle can offset many problems that she may face in her life. Finally, Fred described how DBT skills helped him while at the RTC. He continues to practice DBT skills as an adult and was able to cite each skills training module during the interviews. Although Lexy described learning DBT skills in multiple different treatment settings, she did not find the intervention helpful.


**Changed Opinion About Mental Health Treatment Across Time**

This theme was generated by participant descriptions of experiencing a change in perception about treatment over time. Participants discussed their initial dislike for mental health treatment when they were a child, however, every participant discussed how their perception regarding treatment changed to be more positive as they advanced into their adult life. The majority attributed this change in attitude, in part, to their experience in the RTC as a child. The following five codes comprise this theme: change of attitude/thoughts, psychotherapy, aftercare, attitude about treatment, and RTC treatment. Participants often attributed their change in attitude about treatment to a positive experience with individual psychotherapy while in the RTC. They indicated feeling as though treatment was not useful at first, however, described their change in opinion post RTC discharge and as they developed into adulthood. Participants eventually recognized the positive elements associated with their RTC treatment, and with mental healthcare in general. Many participants continued engaging in mental health treatment after the RTC, especially psychotherapy. Commonalities between participant experiences are described below.

Every participant, except for Kate, described how their time in the RTC changed their opinion about mental health treatment. Fred, Lexy, Jill, May, and Eve indicated their experience in the RTC helped them recognize when they need help from a psychotherapist. Fred, May, and Eve also described how the help they received while at the RTC gave them a positive view about psychotherapy and helped them understand how psychotherapy be useful. Interestingly, all six participants sought mental healthcare in some capacity post RTC discharge, and as adults. Although Kate’s experience in the RTC was not focused on her treatment, she referenced her desire to engage in psychotherapy as an adult (and her attempt to do so during the pandemic).
Fred, May, and Eve also described how one’s attitude toward treatment can impact the efficacy of the interventions. They all came to realize that their level of engagement in the RTC programming impacts their degree of benefit from the interventions. For example, Eve and Fred expressed regret about not taking their treatment more seriously during their first RTC admission. They both had increased engagement during their second admission and noticed that they experienced greater benefit the second time. May also described feeling regret associated with her decreased engagement in RTC treatment during her last few months because as her disengagement increased, her benefit from treatment decreased.

The ways participants described their psychotherapists also shed light on their attitudes about treatment. For example, Eve and May described their RTC therapists very positively. In contrast, Lexy described her RTC therapists negatively, however, described her experience with psychotherapy as an adult positively. Lexy acknowledged her time in the RTC helped her recognize when she may need mental healthcare, and she engaged in trauma focused therapy as an adult. Lexy felt trauma therapy was incredibly helpful and is what she needed the whole time. Jill also described feeling increased openness to engaging in treatment and recognized how mental healthcare has helped her. Similarly, Fred felt as though his ability to start services at the gender and sexuality clinic was made possible due to his RTC treatment, and he found a therapist in this process who greatly helped him. Finally, Eve described feeling as though her RTC treatment resulted in positive therapeutic experiences post-discharge.

**Increased Understanding and Awareness of Mental Health**

This theme was generated by participant descriptions associated with how their experience in the RTC helped them understand the variety of mental health difficulties others face. The following six codes comprise this theme: exposure to negative behaviors, maladaptive
coping, increased empathy, rule violations, mental illness symptoms, and view of sexuality. Several participants discussed how their RTC experience increased their empathy for others experiencing mental health difficulties. Participants also experienced increased understanding about why people may engage in maladaptive coping. Moreover, participants demonstrated appreciation for diverse sexual identities, which were impacted their RTC treatment.

Participants described how their exposure to negative behaviors and engagement in rule violations while at the RTC increased their empathy for those experiencing mental health difficulties. All participants described witnessing extreme behaviors by other children (and for Kate, adults) in the RTC. The combination between witnessing extreme/maladaptive behavior and their own experience of mental health difficulties has led several participants to be more patient and understanding of others. For example, Fred described having grace for others who may be rude because he recognizes that they may be struggling with significant hardship. May also described experiencing comfort in talking with others about self-harm, and did so with a stranger she met in Walmart. Eve described feeling compelled to continue relationships with others (even if unhealthy) because she understands that they probably need supportive others in their life, as she did in the past. Lexy described her understanding of the mental health difficulties her siblings face and described barriers that are common to people in need of treatment. She connected her adult understanding of mental health difficulties to her experience of transitioning out of IPFs and an RTC as a child.

Participants’ view of sexuality also plays a role in their increased awareness and understanding about mental health. For example, Kate and May were both raised in very conservative, Christian families and were taught that sexual orientations and gender identities other than heterosexual and cisgender were a sin. Kate and May both experienced mental health
symptoms associated with their sexual orientations (lesbian and pansexual) because what they were being taught by their family and religious backgrounds did not align with their identities, thus causing them to feel abnormal and sinful. Fred also described how his status as a sexual minority (transgender and at one point gay) greatly impacted his mental health as he experienced bullying and lack of acceptance from peers. Fred, Kate, and May all described how their experience in the RTC as a child impacted their view of sexuality, and thus their view of themselves. All three participants described becoming comfortable and proud of their sexuality as they developed into adulthood, and they described understanding how non-acceptance negatively impacted their mental health. Therefore, they all identify as accepting and open individuals and strive to practice acceptance of others, especially those who may be struggling.

**Developed and Maintained Impactful Relationships**

This theme was borne from participant descriptions of the relationships they developed while in the RTC. Moreover, ways the relationships impacted participants post-discharge was also discussed. The following five codes comprised this theme: social/family support, interpersonal conflict, staff relationships, peers, lost touch with RTC friends. Participants described their experiences with both positive and negative relationships formed while in the RTC.

May spent the most time describing her experience with relationships while in the RTC. She discussed how staff members displayed poor boundaries and she also described ways her relationships with peers had a healing impact on her. May spent significant time describing her romantic relationship with an RTC staff member, which is a relationship that continued for at least one year post discharge. Although May does not regret having a romantic relationship with her staff member, she acknowledged that it negatively impacted her treatment. She also
described experiencing emotional pain when adolescents left the RTC, as they built strong bonds with one another. May stayed in touch with some of her peers post-discharge via social media, and even dated an adolescent that she had met in the RTC several years after her discharge. She still reflects on transitional objects she has from the RTC and remembers many of her peers’ stories, which inform how she relates to others as an adult (i.e., is more aware of boundaries, more empathetic, more open, and is more sociable).

Fred and Lexy described how their relationships with RTC peers impacted their ability to set boundaries with others. Since they experienced strict rules in the RTC forbidding the disclosure of certain information to peers, they acknowledged the importance of being aware of their level self-disclosure with others in adulthood. Fred and Lexy both described feeling more cautious about who they decide to trust since their RTC discharge.

Jill described experiencing negative peer relationships such that she was tempted to engage in negative behaviors and was taught maladaptive coping skills that she utilized into adulthood. She described how her attempts to gain acceptance from her peers in the RTC impacted her ability to be more open in treatment, she discovered the benefits of being genuine about her experiences with others. Kate and Lexy both described feeling detached from peers in the RTC which increased their appreciation for their friends and family outside of the RTC. In general Kate and Lexy did not mourn any loss of relationships from the RTC.

**Experienced Difficult Transition From the RTC**

This theme was generated from participant descriptions about difficult transitional experiences from the RTC to participants’ next placement. Topics emerged such as the stark change in structure between the RTC and their discharge placement, change in educational settings, and continued mental health difficulties post-discharge. Moreover, multiple participants
were readmitted to either an RTC or an IPF post-discharge. The following five codes comprise this theme: reason for discharge, discharge/closure process, poor education/education, transition after treatment, and discharge process/closure. The way in which participants believe they were impacted by a difficult transition is described below.

Jill and May talked explicitly about their difficulty adjusting to a less structured environment post RTC discharge. For example, Jill described feeling comfortable with the schedule and expectations in the IPF, and then struggled once she returned home as she did not have supportive adults helping her structure her day. She also went from always being cared for by multiple staff members to being the primary caretaker of her mother when she returned home. May described how she noticed a significant difference between the structure and supervision she received at the RTC (i.e., staff telling you when to eat and sleep, asking to use the restroom) and the freedom she experienced post-discharge. May described attending college shortly after her RTC treatment, and she struggled significantly to function on her own at age 16. She had significantly more freedom post discharge than she did while in the RTC, and explained that she was not ready to appropriately handle her newfound freedom.

Fred, Lexy, May, and Eve also all described experiencing difficulty with their education post discharge. They described feeling as though the education they received while in the RTC was subpar and lacked challenge. Therefore, when they attempted to reintegrate into their mainstream educational settings post-discharge, they struggled to keep up due to feeling as though they did not learn necessary foundational knowledge. Fred and Lexy also attended a different type of school setting post-discharge than they had prior to the RTC due to their need for a smaller, more supportive learning environment. Both described feeling as though they fell behind in their education while in the RTC, which contributed to their academic struggles into
adulthood. For example, Fred described feeling as though college took him longer than it would have had he stayed in mainstream education. Lexy described feeling as though she does not have the same depth of knowledge that her peers have due to her being set back educationally in the RTC. Fred, Lexy, May, and Eve all described feeling regret associated with their RTC education. Moreover, they all described feeling as though school was a source of pride for them before their RTC admission, and therefore, felt as though this was dampened while in treatment. These regrets were carried into adulthood.

Finally, every participant described continuing to struggle with mental health difficulties post RTC discharge. Fred, Jill, May, and Eve all described experiencing difficulty when returning home because they did not have access to a staff member at all times of the day, which was troublesome when they needed help processing a difficult experience. Fred and Eve were both readmitted to the same RTC after their initial RTC discharge and Fred, Lexy, Jill, May, and Eve were all admitted to an IPF at least once after their final RTC discharge.

**Summary of Themes**

In sum, the five themes generated from the data demonstrated how participants integrated their experience leaving an RTC as a child into the broader context of their life story. There were many codes that were not utilized for the purpose of answering research question three via thematic analysis. The discarded codes prove to be relevant when answering questions not outlined in this study. Therefore, continuing to answer questions associated with this topic is possible through continued use of this dataset. Thematic analysis in this study aimed to further textualize the experiences of participants by summarizing patterns observed across participants. The thematic patterns can also be observed within participants via review of their narratives. Both approaches to data analysis demonstrate congruency and consistency within the data.
Discussion

The purpose of the study was to understand how adults who transitioned out of an RTC as a child recount their experiences before, during, and after their transition out of an RTC. The emerged data answered the following three research questions:

1. How do adults who transitioned out of an RTC as a child recount their experiences before, during, and after their transition?
2. Which lived experiences do these adults perceive to have been the most impactful in their life trajectory?
3. In what ways have these adults integrated their experience leaving an RTC as a child into the broader context of their life story?

Participant narratives were crafted to answer research questions one and two, and thematic analysis was utilized to answer research question three. Six participants were included in the study which generated a total of 26 hours of interview data. Each participant had a unique story that they told in their own way. Five themes were identified via thematic analysis and reflected patterns observed across participant data.

Narratives

In their narratives, participants shared stories related to their time in an RTC as a child. Participants also took care to describe the context of their experiences, which allowed for thick, rich description of their stories (Creswell & Poth, 2018). Most participants initially told stories associated with negative experiences during their time in the RTC, however, their tone often changed the more that we met and co-constructed the stories (Reissman, 2008; Creswell & Poth, 2018). Negative and painful memories appeared to emerge within stories isolated to the RTC setting, whereas participant tone was often different when considering their RTC experience.
within the broader context of their life. For example, Fred, Jill, May, and Eve all described how their experience in the RTC impacted their life trajectory in a positive way. In contrast, Lexy and Kate did not end up perceiving their RTC experience to be positive for the life trajectory whatsoever.

The telling of the stories adhered to the purpose of the study in that I restoried the data via chronology (Cortazzi, 1993), identified turning points and epiphanies, and described how participants perceived their RTC experience in the context of their life (Creswell & Poth, 2018). Quotes and stories included in the narratives were picked based upon their impact on the reader and their relevance to the narrative wholistically, with the aim to frame the participants’ words in a powerful yet coherent and chronological manner.

A primary takeaway from the generated narratives is the degree to which each participant was dealing with their own life circumstances before, during, and after their RTC admission. Every participant described experiencing hardship and/or trauma which impacted their response to their environment. Each participant was coping the best way they knew how. Most participants experienced significant family hardship and lack of caregiver support before, during, and after their RTC admission. Every participant described how the RTC impacted them in a significant way, whether it be positive or negative. These narratives demonstrate the importance of carefully considering the need for a child’s placement in an RTC, as the experience proves to have a profound impact on the child and their family.

The narratives also demonstrate the importance of identifying clinical readiness to discharge, and participants described being discharged for reasons other than clinical readiness. For example, two participants described how they were either discharged early for the purpose of attending a different treatment and/or due to funding complications (Fred and Lexy). One
participant (May) described staying at the RTC longer than necessary due to a lack of placement options, and three participants (Lexy, Fred, and May) described how they demonstrated behavior incongruent with how they felt, for the purpose of being discharged sooner. Such observations are consistent with the broader literature (Lakin et al., 2007; Scholte & van der Ploeg, 2000; Sunseri, 2001; Vogelsang, 2018). At a minimum, the narratives suggest that admission to an RTC is a significant and impactful decision, and it has consequences that last for years.

There was also consistency between participant characteristics and the broader literature, which became apparent through participant narratives. For example, all six participants experienced some form of maltreatment from others (i.e., peers, caregivers, society), and all experienced some form of trauma. This is consistent with the literature which states that most children enrolled in RTC’s experience some form of maltreatment and/or trauma (Zelechoski et al., 2013; Finkelhor et al., 2007; Weine et al., 1997). Also consistent with the literature was the common experience of CSA among the participants. For example, Kate and Eve both experienced CSA which occurs in approximately 65.0% of the RTC child population (Connor, Doerfler, et al., 2004) and often occurs among children involved with CPS (Becci et al., 2015), with which Kate and Eve were both involved.

Additionally, an important factor in providing TIC to children in RTCs is the opportunity for them to form healthy attachments with safe adults (Lynch & Cicchetti, 1998; Osofsky, 2011). Fred, Jill, and Eve all described experiencing an increased opportunity to form attachments while at the RTC. For example, Fred described experiencing a better relationship with his parents as a result of his RTC treatment, which is consistent with findings from Preyde et al. (2019). Jill described feeling as though she could trust staff members at the IPF, and had desire to reach out to them for help post-discharge. Eve talked about her safe relationship with her RTC therapist.
and her placement with her foster parents, who changed her life for the better. Safe attachment relationships with adults are known to greatly ameliorate the negative affects of childhood trauma (Osofsky, 2011), which are the norm among RTC child populations. Thus, at least three participants described gaining a better attachment relationship as a result of their RTC treatment. These factors increase the likelihood for positive treatment outcomes. This study and the literature demonstrates RTCs can offer safe attachment opportunities for children who have experienced trauma (Gallagher & Green, 2012).

Another consistency between the participant narratives and the broader literature is the tendency for children to make gains in treatment initially and then regress post-discharge (Blader, 2004; Cafferty & Leichtman, 2001; Friedman et al., 2016; Leichtman & Leichtman, 2001; Patel et al., 2018; Whittaker et al., 1988). Every participant was hospitalized and/or readmitted to an RTC post-discharge, which is consistent with the literature (Blader, 2004; Asarnow et al., 1996; Pedersen & Aarkrog, 2001). Also consistent was each participant’s continued struggle with mental health difficulties into adulthood.

A notable connection between the narratives presented in this study and the literature is the participants’ description of the RTC as feeling “like a prison.” Interestingly, participants in Chama and Ramirez (2014) also described their RTCs as having a “‘prison-like’ atmosphere.” In general, there were many similarities between the data obtained in this study and the available literature associated with the topic. These narratives contribute to the literature by providing first hand participant stories aimed at describing how adults recount their experiences leaving an RTC as a child and their identification of impactful events within their life. Moreover, there is limited studies on the topic in general, and especially limited studies utilizing narrative methods and
adult perspectives. Therefore, the presented participant narratives currently fill an important gap in the literature.

**Themes Across Participants**

Thematic analysis communicated different information than the narratives and adhered to the purpose of the study by identifying patterns across participants regarding their experience before, during and after RTC discharge. Themes were identified through use of coding procedures and five themes are comprised by a total of 25 codes, which are listed in Appendix B.

The first theme, “learned and used coping skills,” is partially consistent with the literature, and with Famalette Boylan (2016). In this study, five of the six participants described how they continued to utilize skills they learned while in the RTC into adulthood. In Famalette Boylan (2016), adult participants who lived in a group home as children described learning skills, but not transferring the skills into their life post-discharge. Although participants in both studies identified learning skills while in the RTC, findings in this study were different because participants described having ability to generalize their learned and used coping skills. Learned and used coping skills included the realization of the importance of structure and organization, the formation of social skills, benefits of rigorous exercise and healthy lifestyle, and the utility of DBT skills. The emergence of this theme is promising upon consideration about how RTC treatment helps children long-term, as participants demonstrated how they utilized learned and used coping skills throughout their life. Differences between these findings may be explained by the difference in the type of RTCs in which participants resided. For example, participants in Famalette Boylan (2016) lived in a group home, while participants in this study lived in either an RTC or an IPF. Perhaps, RTCs and IPFs are more effective in helping children generalize their skills, especially into adulthood.
The second theme, “changed opinion about mental health treatment across time,” appears to be a novel finding as I did not find literature as it pertains directly to this category. Much of the current literature describes experiences that participants report rather than describes how and whether participants experienced a change in attitude and/or perspective. Similarly, little literature was found directly related to the third theme “increased understanding and awareness of mental health.” Participants described how they witnessed negative behaviors by peers and learned others’ stories, which increased their understanding and awareness of others. This can be connected with a typical learning process as exposure to new concepts tends to increase understanding of the topic.

There is more literature available as it pertains to themes four and five. Theme four, “Developed and maintained impactful relationships,” proves to be an important and impactful aspect of RTC treatment and was described by every participant in some capacity. Fred, Lexy, and Kate all described utilizing increased caution when forming relationships, a tendency that they developed from their time in the RTC. This is consistent with Keller and colleagues (2021) who also included participants whom described engaging in increased skepticism toward relationships after their RTC treatment. Tatsiopoulou et al. (2020) also cites having discovered similar themes among adults in Greece who lived in RTCs as children. They found the following themes: “relations with peers at the institution” and “relationships with the personnel at the institution.” This study extends beyond the findings in Tatsiopoulou et al. (2020) because descriptions by Kate, Jill, May, and Eve indicate that they also attempted to form relationships with peers and staff while in the RTC. Kate, Jill, and May, in particular, all described how their formation of relationships while at the RTC was a priority, a finding also observed in Gallagher and Green (2012).
Theme five, “Experienced difficult transition from the RTC” is consistent with the broader literature available on this topic. For example, Tatsiopoulou et al. (2020) concluded that the transitional period for children leaving an RTC was “difficult,” as narrated by adults. Similarly, every participant in this study described experiencing a degree of hardship post-discharge as it pertained to their discharge placement, educational transition, and continued mental health difficulties. This study further highlights the importance of the transitional period for treatment outcomes. May, for example, described how her transitional experience would have been more effective had she had opportunity to discharge more gradually (i.e., slowly step-down intensity of care), which is also identified important factor for discharge success by Lyons et al. (2009). Lexy also talked about her negative experience leaving the RTC as she did not feel as though staff members truly knew nor understood her. Her experience leaving the RTC was sad because she left feeling as though she did not form needed relationships with others. In sum, increasing the organization, intentionality, and accurate timing of discharge among this population may be key to increasing positive long-term treatment outcomes (Tatsiopoulou et al., 2020; Vogelsang, 2018).

**Strengths**

There are multiple strengths of this study. The first and most obvious is the participants’ willingness and ability to tell their stories and my effort to keep them engaged in the research process. Participants’ trust in me to tell their stories and represent their experiences was a necessary component of the production of this study. Moreover, the degree to which the RAs and I gained familiarity with the data is another apparent strength. As described, I reviewed each interview prior to conducting any subsequent interviews, and the RA checked every completed transcript before it was finalized. The RA also memoed immediately after each interview and
during each time she reviewed an interview. I also read through each transcript multiple times in
the context of coding and for the purpose of crafting each participant narrative. She frequently
talked with her RAs (i.e., weekly, on average) and debriefed with a colleague in her lab
throughout the process, which further increased her ability to understand patterns within the
dataset. Because researcher familiarity and flirtation with the data is so important in narrative
research (Kim, 2016), this was made a priority and became a focus of the study. Due to the
researchers’ familiarity with the data, I was able to analyze the data at various levels of scrutiny
(i.e., micro and macro; Kim, 2016), which ultimately impacted her ability to write and present
the data in a focused and coherent manner. The goal was that these measures positively impacted
her ability to present and communicate the findings.

Another strength of the study was the way data was organized and how the research
process was documented. I took lengthy measures to ensure that decisions were documented and
justified throughout the process. For example, she kept a master spreadsheet which documented
the nature and modality of each contact made with participants, each lab meeting, and each
consultation meeting. I also memoed about procedural decisions made throughout the study and
kept documentation about the purpose of each methodological decision made. Moreover, she
took care to choose a software program that fit the data organizational needs of the study and
ensured that RAs understood the data management and analysis process.

Another strength of this study was my consistent review of theory and consultation of the
methodological literature throughout the research process. For example, I frequently consulted
the literature when making methodological decisions. She also ensured that all RAs reviewed
assigned texts and understood the theory and purpose of narrative research, and how it applied to
this study. This is a strength because consumers can have confidence that extensive measures
were taken to ground all research activities in the broader literature, and that all methods utilized are widely accepted in the field.

My clinical experience with the population in this study is another strength as she was able to utilize her experience and connect clinical observations with the literature and findings in this study. Additionally, several participants described feeling a sense of security when discussing their experiences because I have first-hand professional experience and knowledge about what it is like to be a child in an RTC. Thus, at least three participants described feeling comfortable to be open about their thoughts and feelings during interviews because of my expertise on the topic. This is a strength because it likely positively impacted the quality and richness of the obtained data.

Lastly, a strength of this study is embedded in a global disaster. The onset of the COVID-19 pandemic occurred soon after proposing this project and prior to data collection. Although the pandemic was initially viewed as a setback, the way data was collected quickly shifted and became a strength of the study. Interviews were initially planned to occur in person, however, the onset of pandemic required communication to occur virtually. This was a benefit for the study because it increased ease in access to participants who were located across the country (i.e., Southern U.S., Midwest U.S., Northern U.S., and Western U.S.). Since every participant was communicating virtually anyway, there was a natural communication pathway in place that allowed for virtual completion of interviews. Moreover, the necessity to complete virtual interviews increased the ease of recording capabilities (i.e., allowed for audio and video recording) and fostered collaboration between me and RAs, who were in different states from one another.
Limitations

As with every research study, this study has limitations. One of the most glaring limitations was my inability to keep Jill engaged, and her completion of two interviews. She is still included in the study because she provided high quality data, although less content than other participants. Learning more about her experience would have meaningfully contributed to the dataset as she demonstrated unique qualities such as hailing from a rural area, being the only participant who resided in an IPF for at least six months as a child and having a dual diagnosis which included a mental health diagnosis and a substance use diagnosis. Jill also began to describe how her limited access to resources impacted her aftercare and overall treatment outcomes. Unfortunately, Jill did not attend our third interview. I contacted her to ask if she would like to reschedule the interview and she later responded and apologized for missing the interview, indicating that she had been re-hospitalized at the time. I then asked if she would be willing to reschedule the third interview, and I did not receive a response.

Another limitation was the lack of response received from participants when they were asked to review their narratives. Completed narratives were sent to Fred, Lexy, and Kate. Unfortunately, Jill was no longer in contact with me at the time, and May and Eve did not respond to my offer for them to review their narratives. Of the participants who requested to see their narratives, none responded with feedback, additions, or changes. This is deemed as a limitation because narrative research relies heavily on collaboration with participants, who are viewed as co-researchers. Moreover, this study utilized a social constructivism interpretive framework which relies on the co-creation of meaning between two people. Although this occurred in the context of interviews and my relationship with participants, it unfortunately did not carry on into the data representation phase of the study.
Since the data was intensively analyzed after all interviews were complete, it is likely that participants’ level of engagement declined due to the gap of time between the completion of interviews and the completion of the narratives. For example, the time in between Fred’s final interview and completion of his narrative totaled one year and nine months. It is likely that had the narratives been written faster and closer to the time in which participant interviews were completed, then there may have been a greater response from participants. The extended time between data collection and data analysis/representation was largely dictated by my unavoidable life circumstances at the time of this study. Ideally, time between data collection, analysis, and representation would be shorter and hopefully result in greater participant involvement.

Another limitation was the order in which interviews were conducted. For Fred, Lexy, Jill, and Kate, recruitment and interview completion were done consecutively. For example, Fred was recruited and completed four interviews. His interviews were then transcribed by RAs. Then Lexy was recruited, and she completed four interviews. Her interviews were then transcribed. Although this was the initial procedural plan for data collection and management, this process was not consistent throughout the study. There were multiple reasons for variance in this process including limitations associated with the IRB process and the way participants were recruited. For example, some participant interviews were completed months after the initial four interviews (i.e., for Fred) due to the need for an IRB amendment. Additionally, May and Eve were recruited at the same time and therefore completed interviews concurrently. Thus, it took longer to transcribe the interviews than when participants were recruited and interviewed consecutively. Moreover, interviews were not necessarily transcribed as close to the time of interview completion as was initially planned. In general, the consistency of the process was interrupted by uncontrolled life circumstances for both me, the RAs, and the participants. This may have altered
the way the I familiarized myself with the data of each participant, and may have impacted individual participant engagement in reviewing research materials (i.e., checking transcripts and narratives).

Lastly, the time limited nature of completing a study for the purpose of a dissertation project is considered a limitation to this study because there were multiple research pathways that were not pursued due to time constraints. For example, additional opportunities for data collection presented themselves throughout the study, and unfortunately, these opportunities were not pursued due to the necessity of completing this project in a timely manner. For example, focus groups could have greatly added to the richness of the data and may have increased trustworthiness of the conclusions. There were also several family members of participants who could have added important perspectives to the narratives. The limitation of ceasing data collection is embedded in the necessity of drawing a boundary due to the unlimited available data. The study would have been stronger had more data been collected. The study may also have never been completed had more data been collected. Justifying the time and place to set boundaries is difficult and was not a perfect science. Future studies conducted by me on this topic may account for the inevitability of the unlimited data available, and the inherent uncertainty of emergent design.

**Future Research Directions**

Due to the limited research available in this area and the novel findings from this study, there are countless directions for future studies in this area. An overarching goal of future research is the continued exploration of how to provide high quality care for children in RTCs (Keller et al., 2021). An important element of high-quality care includes accurate identification of children in need of RTC treatment and accurate identification of their clinical readiness to
leave the RTC. Furthermore, crafting a discharge process that is thoughtful, planned, and client centered appears to be imperative, and was identified as an important factor by almost every participant in this study.

Another question that may be important to answer is whether and how RTC treatment in childhood ameliorates long-term mental health difficulties throughout development. More qualitative research into the topic may help illuminate how this population experiences, perceives, and integrates their experience into their life, and will thus tap into long-term outcomes associated with childhood RTC admission. Identification of perceived factors that impact treatment outcomes and ways to best support successful aftercare is imperative. It may be useful to conduct qualitative interviews with children at various increments of time following their RTC discharge, and then compare child perceptions about their transition with adult perspectives. This may further explain how perceptions and opinions about treatment change over time and with development.

More studies exploring the experience of caregivers and other family members would also be useful to gain understanding about the perspectives of those close to the child. Finally, exploring how the various systems involved in a child’s life intersect and impact treatment is important. For example, how may a child experience the competing interests of being involved in an RTC, foster care, a school district, and a family system; and how might these experiences impact their long-term treatment outcomes? In sum, there is a lot more to learn and further advancing the literature in this area would prove beneficial to the many children and families that are impacted by an out-of-home placement in an RTC.
Conclusion

The purpose of this narrative research study was to understand how adults who transitioned out of an RTC as a child recounted their experiences before, during, and after their transition out of an RTC. Six participants were included in the study and produced a total of 26 interviews. Interviews were transcribed, coded, and restoried to address the following research questions:

1. How do adults who transitioned out of an RTC as a child recount their experiences before, during, and after their transition?
2. Which lived experiences do these adults perceive to have been the most impactful in their life trajectory?
3. In what ways have these adults integrated their experience leaving an RTC as a child into the broader context of their life story?

Research questions one and two were addressed via use of narratives and research question number three was addressed via use of thematic analysis. Open coding and memoing was utilized for both narrative construction and thematic analysis. More specifically, narratives were constructed by the process of restorying which included use of selective coding and chronology (i.e., timeline analysis). Thematic analysis was conducted via use of axial coding and ultimate development of themes (Merriam & Tisdell, 2015).

The final representation of data included construction of six participant narratives and the identification of five themes which include the following: learned and used coping skills, changed opinion about mental health treatment across time, increased understanding and awareness of mental health, Developed and maintained impactful relationships, and Experienced difficult transition from the RTC. In general, findings are consistent with the broader literature,
but also yielded novel findings as this study is one of few that explored adult perspectives regarding their transition from an RTC.

The obtained data adequately answered the research questions and highlights the importance of further inquiry on this topic. Rigorous narrative methods were utilized, and a large and rich dataset was obtained. Participants involved in this study demonstrated significant trust and openness, which made completion of the study possible. Their stories richly communicate their lived experiences and demonstrate how their experiences have significantly impacted their life and wellbeing. The findings from this study can inform RTC treatment programs and inspire future research targeted to improve upon this powerful intervention utilized with children in society who struggle the most. In general, there were mixed reports by participants regarding the utility of their RTC treatment. Some participants found it completely useless, some found it helpful, and some reported mixed results. Further exploration of effectiveness and outcomes may further clarify our understanding of the utility of RTC treatment.

Practical Applications

There are many implications for clinical practice that can be drawn from the findings. One important recommendation I make to professionals working with children in RTCs is to be mindful and intentional about treatment planning and discharge planning. Findings from this study indicate that children experience better treatment outcomes when given time to adjust to an upcoming discharge. Moreover, providing opportunity for children to prepare for a healthy ending of relationships appears to improve their adjustment post-discharge. It is recommended that RTC professionals prepare a thoughtful and tiered plan aimed at helping children separate from important relationships that they developed while at the RTC. For example, May indicated that it may be helpful for RTCs to implement options for children to continue to check-in with
RTC staff post-discharge for the purpose helping children separate from their RTC experience in a healthy way. Ongoing contact with important staff members could also provide important interpersonal modeling for children and increase their experience of a positive attachment relationship.

Participants also described experiencing difficulties with transitioning from the structured environment in an RTC to a home environment. Participants cited that their transition felt like a jarring experience because they quickly transitioned from living in a highly structured environment to living in a home environment. Emphasizing a stepped-down approach and monitoring a child’s progress in the context of their entire treatment journey is recommended because most children will experience treatment and mental health services before and after their RTC admission. Thus, conceptualizing their clinical cases in the context of their entire treatment process is highly recommended for the purpose of increasing the likelihood for a smooth transition and adequate continuity of care. Utilizing the transitional process as a form of intervention and emphasizing the important impact that the discharge process has on treatment outcomes should be considered as an important component of every child’s RTC treatment.

I also recommend that RTCs emphasize the inclusion and treatment of a child’s family system, when appropriate. Research indicates the importance of including a child’s family in treatment, and findings from this study indicate that family may play an important role in improving continuity of care and easing the transition out of an RTC. It is recommended that RTC staff work with caregivers on finding ways to ensure that aftercare recommendations are utilized and that caregivers are prepared for the potential difficulties that the child may continue to experience post-discharge.
Another recommendation for RTCs treating children is that staff training is emphasized and taken seriously. As mentioned by most participants, their interactions with RTC staff members were not consistently positive. Multiple participants described working with one or more staff members who displayed poor boundaries and/or were undertrained and ineffective at ensuring safety (emotional, physical, and relational). Moreover, as described by Lexy, an over-emphasis on “worksheets” and skills training has potential to cause relational harm and disengagement of the child in their treatment. Participants who did have positive experiences with one or more RTC staff members described long-lasting positive effects. I recommend that RTCs train staff in attachment theory, trauma informed care, boundary setting, and relational intervention. I also recommend that RTCs pay careful attention to staff burnout and take care to adequately compensate and not overwork direct care staff members.

Due to the need for improved RTC staff training and support, I highly recommend that RTC funding sources be challenged to increase funding for RTC programs for the purpose of bettering the lives and treatment outcomes among children that are served by this intervention. I recommend that insurance companies and government funding sources be challenged to increase RTC funding and that they ease pressure placed on RTC programs to decrease a child’s length of time in the RTC. A child’s RTC treatment should be targeted, planful, and not rushed. Research demonstrates improved outcomes among children who have time and opportunity to discharge from the RTC in an intentional and thoughtful way.

Lastly, I highly recommend that RTCs pay careful attention to the academic needs of each child served. Most participants described having a negative academic experience while in the RTC, citing that their academic rigor was inadequate. Three participants stated that their RTC treatment experience hurt them academically, which impacted their ability to accomplish their
future educational and career goals. Most participants indicated that they had previously excelled in school and found school to be a positive outlet. While at the RTC, participants reported experiencing significantly low academic expectations which not only hurt their academic progress, but also harmed their self-esteem and ability to cope. Thus, I highly recommend that RTCs make considerable effort to meet the academic needs of each individual child and be mindful to avoid implementing expectations that are too low.

I hope that these recommendations are useful for RTCs and professionals who work with children in RTCs. I believe that there is significant potential for RTCs to provide impactful and effective treatment to children in need of the service, and I also believe that there are many aspects of RTC treatment that can be improved for the purpose of optimizing treatment outcomes.
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Appendices

Appendix A: Institutional Review Board Approved Documents

Figure A1. Electronic Recruitment Flyer

Did you or someone you know live in a residential treatment center (RTC) as a child?

Adults who lived in an RTC when they were a child are invited to participate in a research study!

Who?
- Adults between the ages of 18 and 64 who lived in an RTC located in the United States for at least six consecutive months when they were under the age of 18.
- Individuals who speak fluent English and are willing to verbally share their stories and experiences.
- Those with online videoconferencing capabilities.

What?
- Participate in at least three, 60-minute interviews with Alison Vogelsang, M.A., a USD clinical psychology graduate student.

Where?
- Interviews will be conducted via online videoconferencing through use of platforms such as Zoom, Skype, or Facetime, etc.

Why?
- Results of the study will provide rich information about what it was like to live in an RTC and then leave the RTC as a child ultimately aimed at improving long-term treatment outcomes for children in RTCs.
- As part of the clinical psychology graduate program at the University of South Dakota (USD); Alison Vogelsang, M.A., is conducting a qualitative study aimed at better understanding adult perspectives of their experience residing in and leaving an RTC when they were a child.

How?
- Please contact Alison Vogelsang, M.A. via email at Ali.Vogelsang@coyotes.usd.edu or via phone at 605-658-3710.
- Participants will be compensated up to a total of $75 for their participation in the study.
Did you or someone you know live in a residential treatment center (RTC) as a child?

Adults who lived in an RTC when they were a child are invited to participate in a research study!

Who?
- Adults between the ages of 18 and 64 who lived in an RTC located in the United States for at least six consecutive months when they were under the age of 18.
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UNIVERSITY OF SOUTH DAKOTA

Informational Script about the Study

For use when communicating with participants:

Thank you for your interest in the study. The study is called: *A Narrative Study Describing the Transition from Residential Treatment as a Child: An Adult Perspective.* We ask for participation from adults who were enrolled in a residential treatment center in the United States as a child for at least six consecutive months. You will be asked to verbally share your experiences and stories associated with living in a residential treatment center as a child. Of particular interest is your experience leaving the residential treatment center. The goal of the study is to obtain a deeper understanding of what it is like for children to leave a residential treatment center that they resided in for a period of time. Results aim to improve treatment outcomes for children in residential treatment. We require that participants speak fluent English and are willing to engage in a professional conversation/discussion with Ms. Vogelsang for the purpose of sharing your stories. You will be asked to participate in at least three, one-hour interviews via videoconferencing through use of a platform such as Zoom, Skype, or FaceTime, etc. You will be compensated up to a total of $75 in which $25 will be paid upon completion of the first interview and $25 will be paid upon completion of the third interview. Should the researchers need more data (i.e. more discussion with you), you will be asked to agree to complete more interviews. You will be compensated an additional $25 upon completion of a fifth interview. You are welcome to review the consent form and/or take time to consider whether you would like to participate.
UNIVERSITY OF SOUTH DAKOTA
Informed Consent for Participation in Research

Title of Project: A Narrative Study Describing the Transition from Residential Treatment as a Child: An Adult Perspective

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Other Investigators: Craig McGill, Ed.D.
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Chelsey VanNess, M.A.
Morgan Johnson
Jenna Sorensen, MSW

Purpose of the Study: You are invited to participate in a research study aimed to explore your experience leaving a residential treatment center (RTC) when you were a child. The purpose of this research study is to better understand your experience living in an RTC and transitioning out of it as a child. We hope to gain information that will ultimately help RTCs improve treatment and improve the transitional period in which children leave the facility.

Procedure: Approximately 15 adults who were enrolled in an RTC for at least six consecutive months as a child will participate in the study. Your participation requires significant collaboration with the primary researcher, Ms. Vogelsang, who will conduct at least three, one-hour interviews with you aimed at understanding your experiences in-depth. You are the expert in your own experiences and will be prompted to tell stories associated with your experiences. Interviews will be conducted via videoconferencing with use of a platform such as Zoom, Skype, or Facetime, etc. All interviews will be audio and video recorded. All interviews will be transcribed into text format and analyzed for content and meaning. If interested, you will have the opportunity to review your transcript to ensure that it accurately reflects the interview content.

Risks: The risk for participating in this research is minimal and does not exceed the risk you encounter in your daily life. It is possible that the questions you answer may cause you to feel upset because you will be reflecting on potentially distressing or difficult experiences in your life. You will be provided with a list of confidential resources prior to beginning the first interview. If you need immediate assistance, you may contact the Helpline Center by calling 211 or by texting your zip code to 898211. You may also dial the 24/7 National Suicide Prevention Lifeline at 1-800-273-8255 or call 911 in the event of an emergency. Should you feel distressed during the interview and your ability to participate...
becomes compromised, the interview will be stopped and may be rescheduled at a later date, or not at all.

**Benefits:** The direct benefits to you are minimal. However, in the future, this research will benefit children enrolled in RTCs. Your agreement to participate in this research study will help children enrolled in RTCs by improving their experience transitioning out of an RTC which impacts their overall long-term functioning.

**Duration:** This type of research requires multiple hours of interviews, at a minimum. You are asked to participate in at least three, one-hour interviews on separate occasions.

**Statement of Confidentiality:** If this research is presented or published, no information that would identify you will be included. The results will be presented only as unidentified quotes, and information by which you could be identified will not be linked to your responses. Your interview and demographic information will be treated confidentially.

**Mandatory Reporting:** The researchers are mandatory reporters of child abuse and/or neglect, and of abuse and/or neglect of vulnerable adults. If you share information about past or current child/vulnerable adult abuse and/or neglect to any of the researchers, you will be encouraged to report such incidents to the proper authorities. However, you will not be required to do so. You will be provided with information about how to make a report of child/vulnerable adult abuse and/or neglect prior to beginning the first interview.

The researchers are also mandatory reporters of risk for suicide and homicide. If you disclose experiencing thoughts of harming yourself or someone else during an interview, the interview will be stopped, and you will be encouraged to contact confidential mental health resources. You will be encouraged to contact resources before ending the interview. If Ms. Vogelsang deems there to be imminent risk for harm, she will encourage you to call 911. If you do not call 911, Ms. Vogelsang may call 911 on your behalf in which case your confidentiality may be compromised.

**Right to Ask Questions:** The researchers conducting this study include the primary investigator, S. Jean Caraway, Ph.D., and the primary graduate student researcher Alison Vogelsang, M.A. Other individuals involved in the research study include Craig McGill, Ed.D.; Chelsey VanNess, M.A.; Blake Warner, B.S., Morgan Johnson; and Jenna Sorensen, MSW. If you have any questions about the study, please contact either Dr. Caraway or Ms. Vogelsang at (605) 658-3710 between 8:00AM and 5:00PM Monday through Friday before initiating participation in the study. If you have questions, concerns, or complaints about the research after reviewing this form, you are also encouraged to contact either of these individuals.

If you have questions regarding your rights as a research subject, you may contact the University of South Dakota (USD) Institutional Review Board (IRB) at 605-658-3760. You may also call this number with problems, complaints, or concerns about the research. Please call this number if you cannot reach research staff or if you wish to talk with someone who is an informed individual and is independent of the research team.
General information about being a research subject can be found on the USD IRB website https://www.usd.edu/research/orsp-home.

**Compensation:** You are eligible to receive up to a total of $75 for your participation in this study. You will receive $25 upon completion of the first interview and $25 upon completion of the third interview. Should the research team determine that more than three interviews are needed, you will have the option of agreeing to participate in more interviews. Should you agree to participate in more than three interviews, you will receive $25 upon completion of a fifth interview. You may choose to receive payment either via electronic means (i.e. Venmo or Paypal) or via physical bills sent to you in the mail at your preferred address.

**Voluntary Participation:** You do not have to participate in this research. You do not have to answer any questions that you do not wish to answer. You may stop your participation at any time without any penalty. You may refuse to participate or choose to discontinue participation at any time without losing any benefits to which you are otherwise entitled. For example, if you choose to stop either the first or second interview, you will still be compensated $25 (which is paid upon completion of the first interview).

If you are withdrawn from the study, you will receive compensation consistent with the number of interviews that were completed. For example, if you are asked to withdraw from the study after the second interview, you will be compensated $25 (which is paid upon completion of the first interview). You may be withdrawn from the study if researchers feel as though you are unable to engage in an appropriate relationship with the researchers such as if you were to act in a threatening or socially inappropriate manner, or if you are unable or unwilling to share your stories associated with your experience living in an RTC as a child.

The investigators thank you for considering participating in this research project.

Please keep this form for your record and for future reference.

You may schedule an individual appointment to ask questions about the study before verbally agreeing to participate. If you have any questions about the study before consenting, please contact Ms. Vogelsang via email at Ali.Vogelsang@coyotes.usd.edu or via phone at (605)-658-3710. If you fully understand the information contained in this document and would like to participate in the study, please provide verbal consent before proceeding with your participation.

Your verbal consent indicates that this research study has been explained to you, that your questions have been answered, and that you voluntarily agree to participate in this study. You will receive an electronic version of this form.
You may make a report of **suspected child abuse and/or neglect** in South Dakota by:
- Calling/dialing 1-877-244-0864 between 8:00AM and 5:00PM Monday through Friday
- Calling local law enforcement
- Visiting the website below for more information: https://dss.sd.gov/childprotection/reporting.aspx

If you are reporting child abuse and/or neglect in a different state, please visit the Child Welfare Information Gateway by:
- Visiting the website: https://www.childwelfare.gov/topics/responding/reporting/how/ for a list of phone numbers and resources.

You may make a report of **suspected abuse and/or neglect of a vulnerable adult** in South Dakota by calling the South Dakota Department of Human Services (DHS) in your county. You may find the DHS county phone numbers by:
- Visiting the website: https://dhs.sd.gov/ltss/offices.aspx
- Emailing adultprotectioncomplaint@state.sd.us

You may also make a report by:
- Contacting your local law enforcement agency

If you are reporting abuse and/or neglect of a vulnerable adult in a different state, please visit the National Adult Protective Services Association (NAPSA) by:
- Visiting the website: https://www.napsa-now.org/get-help/how-aps-helps/ for a list of phone numbers and resources.
UNIVERSITY OF SOUTH DAKOTA
Confidential Mental Health Resources

In the event of a medical and/or psychiatric emergency or if you are experiencing thoughts of harming yourself or someone else, please call/dial 911 to access emergency services.

In the event that you may need immediate mental health services, you may contact the National Suicide Prevention Lifeline by:
- Calling/dialing the number 1-800-273-TALK (8255)
- Visiting the website at: https://suicidepreventionlifeline.org

The National Suicide Prevention Lifeline provides free and confidential support for people in suicidal crisis or emotional distress 24 hours, 7 days per week.

In the event that you need access to confidential mental health or supportive resources, you may contact the Helpline Center by:
- Calling/dialing the number 211
- Texting your zip code to 898211
- Emailing help@helplinecenter.org
- Visiting the website at: http://www.helplinecenter.org

The Helpline Center answers phones 24 hours, 7 days per week and can help connect you with needed resources provided by government, social services, non-profits, and mental health facilities. The Helpline Center also provides suicide prevention and crisis support and serves most counties in South Dakota and several counties in southwestern Minnesota. The Helpline Center is not a directory service. You may reach the directory service by calling/dialing the number 411.

If you are a student at the University of South Dakota (USD), you may access services at the Student Counseling Center (SCC) by:
- Calling/dialing 605-658-3580 between 8AM and 5PM Monday through Friday
- Calling/dialing 605-677-5432 to contact university police (UP) after hours, UP may contact an on-call SCC crisis counselor
- Calling/dialing 9-911 to contact UP in the event of an on-campus emergency
- Visiting the Cook House at 605 East Clark Street, Vermillion, SD between 8AM and 5PM Monday through Friday
- Visiting the SCC website at: https://www.usd.edu/student-life/scc

The SCC provides free and confidential mental health services to students enrolled at USD.
Figure A7. Interview Protocol

Interview #1:

1. Do you have any questions before we begin?
2. How did you learn about this study?
3. How did you become interested in participating in this study?
4. What is your personal background (e.g. race, ethnicity, age, gender, sexual orientation, marital status, job status, socioeconomic status, etc.)?
5. Tell me about yourself.
6. How did you come to live in a residential treatment center (RTC) as a child?
7. Tell me about the RTC(s) you lived in.
8. In our next interview, we will discuss your experiences while living in the RTC and how you believe these experiences have impacted you. Before we conclude, is there anything else that you would like to discuss today?

Interview #2:

1. What have you been thinking about in regard to your experiences since our last interview?
2. What were the circumstances surrounding your admission to an RTC as a child?
3. How would you describe residing in an RTC as a child?
4. Tell me about your experience leaving the RTC.
5. Describe what it felt like to leave the RTC.
6. Explain what may have stood out to you about this experience.
7. How did leaving the RTC impact you?
8. Is there anything that you would like to tell me that I did not ask you about today?
Interview #3:

1. What have you been thinking about in regard to your experiences since our last interview?

2. Have you thought about any other experiences related to our previous conversation that you would like to share with me?
   a. What did you remember about residing in and leaving an RTC after we last spoke?

3. How have your perspectives and attitudes about residing in and leaving an RTC as a child changed over time?
   a. How did you feel about living in an RTC as a child and how do you feel about it now?

4. How does your experience residing in and leaving an RTC as a child fit into your life trajectory?
   a. How have these experiences impacted your life today?
   b. Describe a way in which you feel like these experiences have impacted you.

5. What would you suggest that may improve the transitional experience for children leaving an RTC?
   a. How may have this process been different?

6. If your adult self could talk to the child you were when you left the RTC, what would you say?
## Appendix B: Codebook

<table>
<thead>
<tr>
<th>Themes &amp; Categories</th>
<th>Codes</th>
<th>Evidence</th>
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| **Learned and Used Coping Skills** | 1. Learned strategy/habits  
2. Organization/structure/strict rules  
3. Positive coping skills  
4. Social skills | All participants cited learning skills in their RTC program that they used later in their adult life. |
| **Changed Opinion About Mental Health Treatment Across Time** | 1. Change of attitude/thoughts  
2. Psychotherapy  
3. Aftercare  
4. Attitude about treatment  
5. RTC treatment | Majority of participants talked about how they continued to seek support for their mental health into their adult life. Many of them talked about their dislike for treatment in childhood and how their opinion about treatment changed over time. |
| **Increased Understanding and Awareness of Mental Health** | 1. Exposure to negative behaviors  
2. Maladaptive coping  
3. Increased empathy  
4. Rule violations  
5. Mental illness symptoms  
6. View of sexuality | All participants talked about having a better understanding and awareness of mental health after being in a RTC program. Other participants talked about being more open about their mental health and willing to talk with others about their difficulties. Participant views of sexuality were also shaped in the RTC and increased their understanding and awareness of mental health as adults. |
| **Developed and Maintained Impactful Relationships** | 1. Social/family support  
2. Interpersonal conflict  
3. Staff relationships  
4. Peers  
5. Lost touch with RTC friends | All participants experienced developing and maintaining relationships while they were in RTC. Majority of participants developed positive relationships with peers and staff members while in their RTC program. Many of them developed better social skills because of these relationships. Participants also described trying to maintain relationships with their caregivers while they were in an RTC program. |
After discharge many talked about losing the connections they made.

| Experienced Difficult Transition From the RTC | 1. Reason for discharge  
2. Discharge/closure process  
3. Poor education/education  
4. Transition after treatment  
5. Discharge process/closure | All participants cite having difficulties transitioning from an RTC. Several participants described continuing to struggle with their mental health after discharge and many participants were admitted to an IPF or RTC multiple times. |
Appendix C: Preliminary Study

Prior to proposing and the study described above, a preliminary “mini-study” was conducted per requirements of a graduate-level qualitative research methods class taught by dissertation committee member, Dr. Craig McGill. The “mini-study” study is described here to inform readers about how I prepared and created the study outlined in the above document. This study was also presented in the context of the proposal document for the above study. It is recommended that the reader review the methods sections in the document above prior to reading this section, to ensure that the methods described below are adequately framed and contextualized. All sources referenced in this section are fully cited in the references section located in the document above.

The “mini-study” was designed with the intention of informing the study described in the above document. Per dissertation committee request, the primary investigator, Dr. Caraway, and I sought retroactive approval for the preliminary study through the IRB at USD. The IRB did not deem the preliminary study as constituting research requiring IRB approval, and thus closed the protocol. The collected data was analyzed and is presented below. There is a brief description about the narrative methods used in the “mini-study.” Please read methods sections above to garner more in-depth information about narrative research methods.

Narrative qualitative research methods were utilized, and two in-depth interviews were conducted over the phone with one participant. Data collection yielded 98 minutes of interview material. The purpose of narrative research is to obtain participant stories that express the lived experience(s) associated with a phenomenon (Creswell & Poth, 2018). Collecting data via stories allows for emergence and expression of important messages associated with the research question. Typically, narrative researchers work very closely with one or two participants to co-
create stories through a process called restorying, a method that entails organizing the stories in a meaningful way. Restorying may include reorganizing stories by chronology, by themes, via important turning points, by impactful events, or with a combination of these approaches (Clandinin & Connelly, 2000). Thus, use of narrative methodology requires strong collaboration between researcher and participant(s). Narrative research also utilizes purposeful sampling by recruitment of a participant(s) who has a story to tell about their lived experience(s) associated with the phenomenon of interest (Creswell & Poth, 2018).

The participant in this pilot study was assigned the pseudonym Tom. He is an adult male and was selected for participation due to his experience transitioning from an RTC to another placement as a child. Tom was selected due to his ability to help answer the research question: “What are pivotal experiences and memories associated with transitioning from an RTC to another placement as a child?” His quotes are depicted in blue colored ink for ease of reading.

In this study, the data was organized via categories and chronology. Thus, two modalities of data representation were used: restorying via chronology and thematic analysis. Part of the restorying process entails identifying epiphanies (Denzin, 2001) within the data, which represent “turning points, or disruptions in which the story line changes direction dramatically” (Creswell & Poth, 2018, p. 73). Major events and clear, recounted memories (Czarniawska, 2004) are also presented throughout the restorying process as being important experiences for the plot and data representation as a whole. Analysis focused on the “what” of the stories within the context of sequence/chronology.

In addition to restorying via chronology, findings were also identified via thematic analysis, with the aim to provide deeper and more descriptive meanings (Huber & Whelan, 1999). Findings identified via restorying and thematic analysis are presented within the context
of story chronology. Moreover, the researcher presented the data via use of an embedded writing structure (Creswell & Poth, 2018) and weaved together both the chronology and the patterns within the data which were identified via thematic analysis.

What struck me most about Tom was his resilience and adaptability, as he attended eight residential institutions between the ages of seven and 18. As an adult, he considers himself a “success.” Not only did Tom attend eight RTCs as a child, he also experienced a total of 13 transitions in and out of placements. His transitions represent admissions and discharges from various institutions, and several transitions to and from his home of origin. Tom recounted many problems in childhood, which he believed stemmed from his home life, his mother’s physical abuse towards him, and her addiction to alcohol and drugs. Tom’s home life was described as chaotic, and he appeared to have vivid memories regarding the differences between living at home and living in an RTC. Tom identified hardships and highlights throughout his life all while expressing feeling proud about “being a success.”

Tom’s stories from different institutions were described and ordered chronologically. Important quotes were extracted and utilized to explain identified patterns. The “rough transitions” he experienced from entering and leaving RTCs were typically marked by aggression and violence on the part of other children in the facility. He also explained that there was always an “unwritten rule” that the residents did not “tell on” one another for perceived wrongdoing. Tom also remembered receiving the message that he would always be “sent back” to an institution and subsequently reside in jail as an adult. Tom explained his awareness of which behaviors would warrant him “being sent back” and subsequently allow him to leave his home. He identified his admission to “bootcamp” as his roughest transition and he described vivid
memories of being woken up early in the morning and transported to and from the facility. He recounted the most memorable event from bootcamp.

So I got taken into the shower by one of the drill instructors at the bootcamp and ah, you know, he was, he was pushing me around and kept telling me to hit him, kept telling me to hit him, so like a dumbass, I hit him. And they literally smothered [me] all over the shower and I went to bed that night, and I got woke up at like two or three in the morning and yeah, they sent me there.

Despite experiencing rough placements, Tom also recounted fond memories made during his time in one particular RTC. There, Tom had some of his “most fun times.” He stated that his time in RTCs provided him opportunities he never would have had if he continued to live at home with his family. He felt less stress and a greater sense of security while in a placement and he stated that life was simply “easier” on him and his father when he resided out of the family home. He had the opportunity to engage in “fun” activities and was able to live with the security of “having a place to go” where someone was capable of taking care of him.

Upon reflecting on his experiences while in various placements, Tom described himself as a “success” in his adult life. He stated that “statistically they told me that I probably be in prison for a long time by the time I was 21, and that I never had a chance.” However, he was determined to defy such expectations and he “just pulled my head out of my butt you can call it. I just, literally, I got rid of all my old friends and I just started hanging out with, with ya know a newer crowd of people.” He proudly reported that “I don’t ah drink alcohol and I don’t do drugs.” He also openly admitted that he “gave everything a run,” however, he credits himself for making good choices as an adult. Tom described experiencing success as evidenced by not being incarcerated, in which he proudly reported “when I was finally out of the system I never really
got back in the system.” His openness to share his stories allowed for information to emerge, which produced a clearer answer to the research question. He was also eager to read the final paper submitted for the class and was asked to provide feedback and offer any corrections or clarifications he deemed necessary.

Presenting Tom’s story significantly contributes to the literature as there are few studies examining the experience of transitioning from RTCs from the client’s perspective, especially once they are an adult (Asarnow et al., 1996; Blader, 2004; Connor et al., 2002). Since Tom experienced many transitions between multiple RTCs, juvenile placements, and his home; he provided a rich description about what it was like to enter and leave multiple different placements as a child. Examining his perspective as an adult was important when aiming to understand his perception regarding the effectiveness of his RTC admissions and how he became to consider himself “a success.” Interestingly, Tom only recalled discharging from facilities because he “timed out.” Future studies would contribute to the literature by analyzing reasons for discharge in greater depth. Based upon the Tom’s stories, it became apparent that he was often unsure as to why he left one placement and subsequently admitted to another. Although he could identify plausible reasons, his perception at the time was largely that of uncertainty. It is also important to note that his uncertainty at the time is impacted by his developmental stage and his ability to grasp various concepts. His story appears useful to foster a deeper understanding about how children in similar situations may perceive events related to transitioning and what it may “be like” living in an RTC or another out-of-home placement. There is great need for further exploration of this problem.

The findings from this study informed the above dissertation by highlighting the importance of understanding the phenomenon of leaving an RTC as a child. Tom provided
extensive discussion pertaining to how leaving multiple RTCs impacted him into adulthood. Thus, this “mini-study” shed light on the importance of understanding the depth of these experiences and subsequently working to improve transitions out of RTCs with the aim to improve long-term outcomes. The dissertation outlined above utilized similar methodology to further explore these issues.

In sum, the process of designing and conducting this “mini-study” was to gain familiarity with qualitative research literature, design and implementation, and to richly describe Tom’s story. One takeaway regarding the process of data collection included the learned importance of using at least two recording devices per interview. One device failed during an interview; however, data was preserved due to an appropriately functioning second recording device. Another important lesson learned throughout this process was to ensure that my understanding of the purpose of the study is very clear and defined prior to conducting participant interviews. I learned that “emergent” does not mean unstructured. Although I initially thought that the interview questions were designed to be emergent, I took more care to clearly define my questions and intention behind inquiries in later qualitative work. Additionally, conducting the preliminary study challenged me to engage in a paradigm shift from a quantitative conceptualization of research to a qualitative conceptualization. My experience taking the qualitative course and conducting this study increased my credibility and skillset needed to conduct a high-quality qualitative dissertation study.