

Young Adults in Transition: Factors That Support and Hinder Growth and Change

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Abstract

A therapeutic model referred to as young adult transition programs has emerged to better address the unique developmental challenges found in this age group. This study examined 317 critical incidents that supported or hindered young adults in a therapeutic transition program. The research design used a combination of an instrumental case study and critical incident technique (CIT). Using interviews and the Outcome Questionnaire 45.2, the study explored in-depth the experiences of 17 young adults who were alumni of a young adult transition program. The objective was to better understand the transition experience from a participant perspective and, through the findings, inform program development and evaluation for young adult transition programs. Several significant findings emerged from the data, among them the importance of interpersonal relationships, experiential education and adventure, individualized programming, and community and culture. An understanding of these findings leads to a discussion on transformational mentoring and leadership as well as relational cultural practice and how this can support leaders of transition programs in further research and program development. The limitations of the study are discussed and suggestions for future studies are offered

Keywords: young adults, young adult treatment, critical incident technique, case study, mental illness, relational cultural theory, transformational leadership, transformational mentoring, anxiety, depression, failure to launch, emerging adulthood, transitions, young adult development

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We live in an age and in a society that is increasingly difficult for young people to navigate. While many young people seem to move effortlessly from adolescence to young adulthood, some find the transition difficult if not seemingly impossible. Economic and social changes have deferred the responsibilities of adulthood for many and this has led to Arnett's (2000, 2004) theory on emerging adulthood, a developmental period often characterized by fluctuations in life roles and responsibilities. As a result, emerging adults experience heightened identity exploration, exaggerated beliefs about life possibilities, a sense of instability and negativity, self-focused attention, and feelings of being in between.

Young adult transition programs emerged in the late 1990's to support clients as they exited the highly structured therapeutic environment of wilderness treatment or residential care and learned to navigate the adult world. The National Association of Therapeutic Schools and Programs (NATSAP) defines young adult transition programs as being,

Designed for young people over 18 needing a safe, supportive environment and life skills training as they transition into adulthood. Many offer access to 12-step programs and may have a psychiatric component. Generally they will offer educational programs that are linked to community colleges or universities or provide schooling at their location. Volunteering, employment arrangements, community service and re-integration into the community at large are general components of the programs. Many operate on a small residential model and transition to a community based, independent living apartment model. (National Association of Therapeutic Schools and Programs, n.d.-b, para. 4)

The purpose of this study is to listen to the stories and experiences of alumni from a young adult transition program to understand the critical moments or events that support or hinder growth and change. In a study of mental health utilization for young adults, Pottick, Bilder, Vander Stoep, Warner, & Alvarez (2008) reported that residential care programs are inconsistent in providing appropriate treatment for young adults with mental health disorders and the study states "residential care will likely remain a scarce resource for transition-age individuals until policy, programmatic, and clinical issues are addressed" (p. 385). This research is a step towards understanding directly from young adults what support and services are beneficial during this developmental time period.

Literature Review

Emerging adulthood has been characterized as a developmental stage, between the ages of 18 to 25, with unique social and psychological issues (Arnett, 2000; Irwin, 2010; Park, Mulye, Adams, Brindis, & Irwin, 2006). Nationally, higher rates of depression, substance abuse, and psychiatric issues are reported in this age group (Kessler et al., 2005; Pottick et al., 2008; Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 2010; U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Office of Applied Studies, 2007).

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Epidemiological data from the National Comorbidity Survey indicates that almost half of the population (46.4%) aged 18 years and older will experience either a psychiatric or substance abuse disorder in their lifetime and three-fourths of those lifetime cases start by age 24 (Kessler et al., 2005).

As young adults transition to more independent living situations with increased responsibility and less support, the burden of untreated problems may negatively affect adult functioning (Adams, Knopf, & Park, 2014). Mental health disorders and substance abuse can disrupt education, relationships, career development, and positive civic engagement (Eaton et al., 2008). The difficulties that result from these adverse life experiences can lead to increased isolation, profound ambivalence, and hopelessness. If left untreated these young adults are more likely to experience significant and chronic functional impairment (Kessler et al., 2005). In the last two decades, several therapeutic options have emerged to address the unique challenges faced by young adults.

Since the mid-1990s, research has established a high level of poor outcomes for youth who transition into adulthood after being diagnosed with a serious mental illness in childhood (Davis & Vander Stoep, 1997; Pottick et al., 2008). Despite extensive services while these individuals are in their adolescence, the mental health field is only recently recognizing that we may not be serving these young adults adequately and in a developmentally appropriate manner (Pottick et al., 2008). Those with psychiatric problems in young adulthood have significantly more struggles compared to their peers in their attempt to complete school and acquire adult occupational and social roles (Pottick et al., 2008). However, the majority of young adults with substance use or mental health disorders do not receive treatment (Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 2010). The mental health field needs to better understand how to adapt services and support not only in mental health, but with the unique developmental issues of a young adult.

In the private-pay treatment field there is a particular need to support young adults being discharged from primary treatment such as residential treatment centers, therapeutic wilderness programs, drug and alcohol treatment programs, psychiatric facilities, and therapeutic boarding schools. Primary treatment provides a structured, supportive environment where the individual is often isolated from the temptations and pressure of the real world. The simplified environment and intensive treatment provide individuals with the opportunity to learn new skills and strategies and to increase personal insight into the challenges that necessitated treatment. Research on the process of transition would lead us to believe that therapeutic gains from primary treatment would have increased sustainability if the individual is supported upon discharge to apply what they have learned, and to practice in the real world, yet within a structured and supportive environment (Goodman, Schlossberg, & Anderson, 2006; Mezirow & Associates, 1990; Schreiner, Louis, & Nelson, 2012; Tagg, 2003).

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Young Adult Transition Programs—What Are They?

Young adult transition programs have emerged to help address the need for support as the young adult discharges from the highly structured environment of primary care. As new young adult programs develop, there is a need for quality assurance, oversight, and accountability. There is also a need to understand if the services provided are of value and if they actually contribute to the quality of life and the successful transition of young adults moving toward a healthy and independent life. A foundation has already been laid by the adolescent treatment world. Outcomes and best practice is an important issue for young adult transition programs to address, particularly if they want to place themselves within behavioral healthcare as a valuable part of the treatment process.

Young adult transition programs are designed to assist young people to gain independent living skills within a community that supports healthy relationships, personal growth, emotional coping skills and academic achievement. Clients include young adults who have struggled with substance abuse, poor self-esteem, depression, anxiety, mood disorders and attention deficit disorder who need assistance in making the transition to adulthood. In addition to providing therapeutic support, adults assist students in setting goals, navigating community college courses or vocational options, identifying and obtaining part-time work, and learning and practicing life skills associated with finances and independent living. Frequently, students move through several program phases, each with increasing levels of independence. Recreational activities (i.e., backpacking, snowboarding, rock climbing, etc.) and home living activities (cooking, repair work, gardening, etc.) are usually integrated within the treatment model. Further, students participate in individual and group therapy, attend drug and alcohol support groups, and participate in a community that provides support and encourages independence (P. Phelan, personal communication, February 29, 2016).

There are a wide variety of programs ranging from those that are highly structured and clinical to those that are mentor-based and designed primarily to support college or work experience. Some programs are apartment-based and others incorporate a group-living experience. Staffing patterns also vary. Some are staffed 24/7 while others provide structure and support during the day with no supervision overnight. Some programs are located in a town or city while others are located rurally. Most programs create a structured environment to help young adults reduce harm from unproductive or high-risk behaviors. In addition, the structure helps them gain personal insight and direction through therapy, the social milieu, life-skills education, vocational support, recreation, health and wellness, medication management, and education. Many transitional programs also work with parents to educate them around family systems, separation-individuation, and their role in the therapeutic journey. A high percentage of young adults participating in these transition programs have received prior treatment. Some have been in therapy from an early age, while others have gotten off-track later in adolescence; some have been hospitalized while others have been in residential treatment previously, or in a therapeutic wilderness program.

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Transition programs provide an opportunity for young adults to utilize skills learned in a highly structured environment in the “real world.”

Currently, there are approximately 27 young adult transition programs that are members of the National Association of Therapeutic Schools and Programs, and the number of transition programs has steadily increased since 2000. It is anticipated that expansion will continue. This belief is supported by the positive response and support of the Young Adult Transition Association (YATA). Some of these programs are licensed or accredited by external bodies, such as the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Independent Private Schools Association (NIPSA), or state agencies. Many young-adult programs do not have accreditation or licensure as states often do not offer licensure and accreditation is not mandatory. Some transition programs have gone the route of being licensed as partial hospitalization programs or outpatient programs for mental health or substance abuse (B. Horigan, personal communication, July 8, 2016). Accreditation and licensing is one way that programs can demonstrate quality of care and commitment to performance improvement (Joint Commission for Accreditation of Healthcare Organizations, n.d.). However, it is not yet standard practice for young-adult transition programs, which creates a potential issue around accountability, risk management, and quality of care.

Emerging Research in Young Adult Programs

As the number of private treatment programs increase, more attention is needed to show evidence-based programming. There is public outcry for increased accountability and oversight (Curry, 1991, 2004; Lieberman & Bellonci, 2007; Young & Gass, 2008).

While there is a growing body of outcome research documenting the impact of treatment on adolescent clients in wilderness therapy and residential treatment, similar data about young adults in treatment are conspicuously absent. At the same time, there is growing momentum among people working with young adults to come together collaboratively to address this situation. For example, YATA currently has a research committee that is developing a common measure to use in research efforts across programs. Several young adult transition programs collect outcome data, but sample size is frequently not large enough to be statistically significant. Individuals in the world of young adult treatment are now, more than ever, looking to address these data collection challenges. Certainly, a collaborative and collegial approach will help address the challenge that practitioners face when trying to convert data into meaningful learning.

There are a number of significant gaps in the literature with respect to our understanding of young adult programs. For example, we know little about specific programmatic elements that contribute to the change process (Zimmerman, 1990). While most transition programs incorporate fairly standard

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programmatic elements such as individual, group, family, and milieu therapy, there are no studies that specifically evaluate the efficacy of each of these treatment components. The young adult treatment field would benefit from further research that identifies effective methods that foster growth and change in this pivotal developmental stage. It would be helpful to understand the nuances of effective change methods in order to replicate positive treatment approaches and models. In addition, it is important to understand what clients identify as supporting or hindering their growth. There is no better place to start than with the stories of young adults who have experienced this transitional treatment.

Method

The method of this study included: an exploratory, instrumental case study to frame the context of the alumni perspectives, Critical Incident Technique (CIT) to gather and analyze alumni interviews, and the Outcome Questionnaire 45.2 (Lambert et al., 2004) to gather quantitative data on participant symptom distress and level of function post treatment.

Instrumental Case Study

An instrumental case study provides insight into a particular issue or phenomenon with the expectation that these insights will have utility and transferability to similar situations and be a foundation from which theory develops. Stake (1995) describes a case as instrumental when it is examined to provide insight into an issue or draw a generalization. Case study research provides an in-depth inquiry with the capacity to study complex social phenomena in a holistic and meaningful manner with rich narrative and real-life context (Yin, 2009), while gathering first-hand experience using a variety of data collection methods. Yin asserts that the case study can be an exploratory process to initiate research prior to undertaking a larger and perhaps more quantitative study, or as a tool to provide illustrations in support of quantitative data. In particular, an instrumental case study can help focus future organizational, or programmatic innovation, and can represent a significant contribution to knowledge and theory building. The objective is to understand everyday situations and to use lessons learned from the study to inform the work of other institutions or individuals.

There has been a recent call for an increase in clinical case studies (Behrens, 2015; Carlson, Ross, & Harris Stark, 2012; Ernst, Barhight, Bierenbaum, Piazza-Waggoner, & Carter, 2013; Leary, 2014; Macgowan & Wong, 2014) because they are considered a useful research design for clinical practice across professions including psychology, social work, special education, and counselor education (Bloom, Fischer, & Orme, 2009; Heppner, Kivlighan, & Wampold, 2008; Horner, Carr, Halle, McGee, Odom, & Wolery, 2005; Lundervold & Belwood, 2000). The benefits of case study research explored by Carlson et al. (2012), McLeod (2010) and Yin (2009) support the argument that the instrumental case study is a useful method of research in a field with a dearth of information regarding outcomes and therapeutic factors that support or hinder young adults in treatment.

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Critical Incident Technique

It was determined that the Critical Incident Technique (CIT) within the framework of an instrumental case study was the best method to capture the student experience of supportive and hindering incidents. An advantage of CIT is its usefulness in the early stages of understanding a phenomenon (Chell, 2004) and as stated previously in this report there is a paucity of research in the field of young adult treatment. CIT has been used as a means of reflection and enhanced understanding (Chell, 2004) and can help create a better understanding of specific practices and beliefs (Tripp, 1994). Particularly relevant to this study is the use of CIT in the therapeutic field of practice. In the last four decades, CIT has been more often used within a constructivist framework (Butterfield, Borgen, Amundson, & Maglio, 2005), and in a therapeutic context. Examples are found in the following studies: Wark (1994) used the technique to study clients' and therapists' perception of change in therapy. Bedi, Davis, and Williams (2005) used CIT to identify and categorize the variables that clients consider important for forming and strengthening a positive therapeutic alliance. Chouliara, Karatzias and Gullone (2013) researched survivors' experiences of recovering from childhood sexual abuse, while Khandelwal (2009) used CIT to gain students' perspectives on teaching behaviors that differentiate excellent from poor performance of undergraduate college teachers. Plutchik, Conte, and Karasu (1994) used the technique to obtain a list of client behaviors that create difficulty for psychotherapists.

Flanagan's (1954) five phases of a critical incident study guided the procedures of this study and as with other researchers the process was adapted to fit the purpose of the research (for a detailed account of these phases see Cohen & Smith, 1976; Freeman, Weitzenfeld, Klein, Riedl, & Musa, 1991).

CIT organizes the reported incidents around three stages used to understand and make meaning of an event (Butterfield et al., 2005; Holloway & Schwartz, 2014; Schwartz & Holloway, 2014):

1. Antecedents—events or thoughts that precede the critical incident;
2. The critical incident or experience with a detailed description;
3. The outcome, consequence, or impact.

Critical incidents are not “things” which exist independently of an observer and are awaiting discovery like gold nuggets or desert islands, but like all data, critical incidents are created. Incidents happen, but critical incidents are produced by the way we look at a situation: a critical incident is an interpretation of the significance of an event. To take something as a critical incident is a value judgment we make, and the basis of that judgment is the significance we attach to the meaning of the incident. (Tripp, 1994, p. 8)

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Young Adult Transition Program

Dragonfly Transitions is a program for young adults discharging from a primary treatment setting such as wilderness therapy or a psychiatric setting. The program is designed with progressive phases and a variety of living environments based on student interest and readiness. The goals include an opportunity for real world experience while providing a stable, supportive environment where students can try new things. Students can attend college, volunteer, work, and engage in a variety of fitness and recreational activities. In 2016, Dragonfly Transitions earned Behavioral Health Care Accreditation through the Joint Commission - the non-profit body that accredits and certifies thousands of U. S. health care organizations (see Joint Commission for Accreditation of Healthcare Organizations, n.d.-a).

Participants

Participants were alumni of Dragonfly Transition between the years of 2010 and 2015. The sample size started with 266 alumni and any student who was enrolled with the program from 2010 to 2015 was considered for the sample. Several alumni did not have current contact information in the electronic health care record and were eliminated from the sample, along with any alumni that were known to be in active psychosis or were currently residing at a treatment program. Any student who was a client of the author while at the program was removed from the list due to ethical considerations. The first author is a co-owner of the program and provides clinical services to some clients in the program. To maintain clinical and research ethics, the first author did not influence and was not involved in the selection or invitation of participants. Alumni were informed that their name and participation would be kept confidential to support credibility, trustworthiness and to manage bias of the participant feeling obligated to respond in any particular manner. The final potential sample included 188 alumni and an invitation was sent out via email with an explanation of the research and the process to participate.

Demographics. The length of stay amongst the sample ranged from 61 days to 618 days. The average length of stay at the program is 274 days, with the average length of stay among those that participated in the study, 329 days. Twenty-one alumni responded to the initial invitation; two declined to participate, and two did not follow up to schedule an interview, making a total of 17 alumni interviewed. The average age of participants in the study was 23.5 with a range from 21 to 26 years of age and a median of 23 years of age.

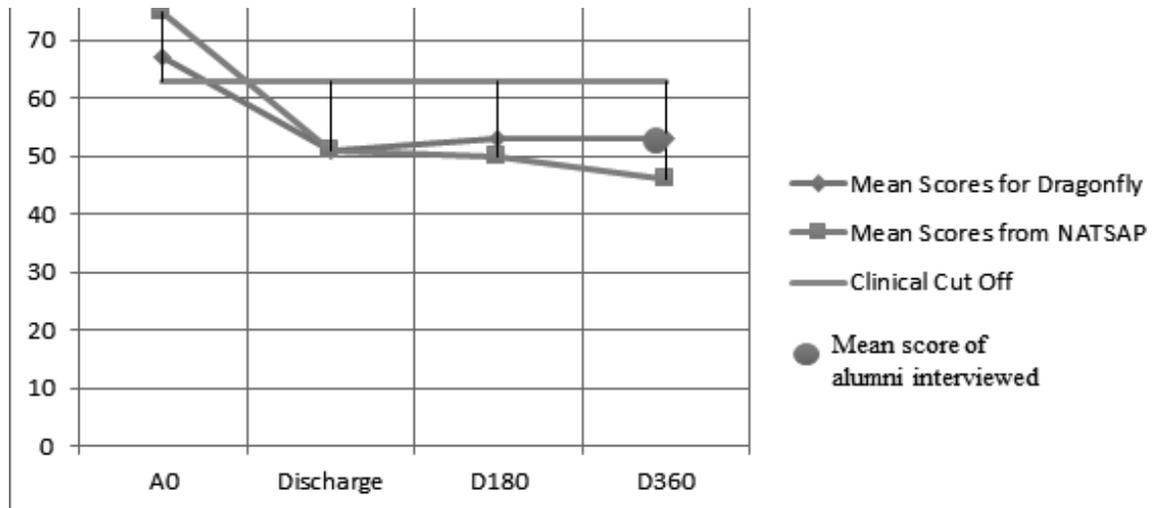
The 17 participants self-identified with a range of clinical diagnoses that is congruent with a typical student. Diagnoses included: obsessive compulsive disorder, co-dependent relationships, post traumatic stress disorder, anxiety, social anxiety, depression, suicidal ideation, substance abuse/addiction, bulimia, bipolar disorder, trauma, mood disorder, and low self-esteem. The most commonly mentioned, as is true for most students, was anxiety and depression.

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Outcome Questionnaire 45.2.

In this study the OQ-45.2 is used to compare the mean OQ-45.2 score of all interviewed participants to NATSAP OQ-45.2 research data, and the Dragonfly Transitions OQ-45.2 research data (Figure 3.1). A score of 45 is representative of a community sample, and a score of 63 is the clinical cut off (Lambert et al, 2004). The mean OQ-45.2 score of study participants is 52.

Figure 3.1. Mean OQ scores from Dragonfly, NATSAP and alumni interviewed for dissertation.



Interviewing Method

Written consent and authorization was obtained prior to the start of the interview process. A trained interviewer conducted the interviews. See Appendix A for the interview protocol. The goal was to gather four supporting incidents and four hindering incidents from each participant (Chell, 2004).

All interviews were recorded and transcribed by an online freelance service with no connection to, or knowledge of the program. The transcriptions of the interviews were then entered into the application, Dedoose, with code identification to protect the confidentiality of the interviewee. Dedoose is an online software system designed to help the researcher organize qualitative data such as interviews (Dedoose, n.d.).

Method of Data Analysis and Interpretation

The transcripts were coded in accordance with CIT structure of coding and the analysis used an emergent coding approach with a constant comparative method of analysis (Holloway & Schwartz, 2014).

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Coding. A code is a researcher-generated construct that symbolizes interpreted meaning of the data for the purpose of pattern detection, categorization, theory building, and other analytic processes. The code is intended to capture and represent the data's primary content and essence (Saldana, 2013). Thus, detailed coding, which reflects interviewees' descriptions and meaning of the event is designed to maintain the integrity of their experience and to ensure the confirmability of the coding process. The coding procedure is considered "emergent coding" and does not rely on inter-rater reliability tests for credibility (Boyatzis, 1998) rather a standard method for coding consistency was adopted. Two trained coders worked with the data. One coder coded all 17 transcripts; the second coder, who had significant experience in CIT research and coding, coded 10 of the same transcripts independently, to ensure consistency of coding approach. Any inconsistencies in interpretation of the transcripts were discussed and consensus reached on participant meaning.

Data analysis. The first step of analysis included a reading of the transcripts in which the primary coder determined the types of incidents being reported and created a classification scheme based on the interviews. Next, the second author and the secondary coder reviewed the types of incidents and determined that they were relevant to the purpose of the study and consistent with CIT method.

The next step of analysis utilized the Dedoose software's query and report capability to organize the thematic codes by incident type to determine if there were any thematic connections across incidents (Schwartz & Holloway, 2014). All codes were analyzed and organized along thematic connections and each categorization included a support or hinder sub-category to further separate and identify incidents. Next, the relationships between the themes were examined. In the final phase, the first author interpreted the findings in relation to the supportive and hindering incidents experienced within the program and as described by the participants of the study sample.

The context of qualitative research and the trustworthiness of a study is established when a validation process is built into all aspects of the research design rather than by an evaluation that occurs at the end of a study (Kvale, 1994). Butterfield et al. (2005) recommended incorporating the following nine data-analysis checks into CIT studies:

- 1) Extract the critical incidents using independent coders; 2) cross-check by participants; 3) independent judges place incidents into categories; 4) track the point at which exhaustiveness is reached; 5) elicit expert opinions; 6) calculate participation rates against the 25 percent criteria established by Borgen and Amundson (1984); 7) check theoretical agreement by stating the study's underlying assumptions and by comparing the emerging categories to the relevant scholarly literature; 8) audio-tape interviews to ensure participants' stories are accurately captured; and, 9) check interview fidelity by getting an expert in the CIT method to listen to a sample of interview tapes. (pp. 490–491)

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All nine of the credibility checks were used in this study to follow the principles of rigor, with extra diligence given the first author's unique relationship to the case.

Results

Analysis of Interviews

Codes for incident types and themes emerged from the participants' description of incidents. The following section examines the types and frequency of critical incidents, participation rate per incident and the participant perspective, including antecedents and outcomes. The critical incidents are organized into conceptual categories that emerged from the thematic analysis: Interpersonal Interactions, Community and Culture, Experiential Education and Adventure and Program Components.

Types and frequency of critical incidents. From the 17 interviews, 327 unique incidents were isolated and characterized as either supporting or hindering. Research participants identified 248 supporting incidents and 79 hindering incidents. These distinct incidents fell into four categories defined as: Interpersonal Interactions, Community and Culture, Experiential Education and Adventure, and Program Components.

Interpersonal interactions reflect the interaction, exchanges and relationship between a participant and another individual. Interactions with mentors were most frequently reported, followed by interactions with a therapist, and then peers. The Community and Culture speaks to the larger context of the therapeutic milieu and reflects how the participants feel about and experience the environment as a whole. Experiential Education and Adventure demonstrates a program philosophy of hands on learning where students reflect on and practice new skills and ways in which to interact in the world beyond treatment. The Program Components are specific parts of the program that participants referenced and include mention of a wide range of specific structure, rules and activities within the program.

Table 4.1 shows the identified critical incidents and the corresponding number of incidents. Each category has a *support* or *hinder* classification and this is followed by the number of sources, which indicate how many alumni mentioned a specific incident, category or theme. A high number of sources indicates consistency and importance of a category; for example, if 14 of the 17 participants or sources talk about mentor interactions this is an indication that the category is an important area to examine.

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Table 4.1

Critical Incidents and Corresponding Number of Incidents and Number of Sources

CRITICAL INCIDENTS	NO. INCIDENTS (NO. SOURCES)	
<i>Interpersonal Interactions</i>		
Mentor Interactions		
	Support	45(14)
	Hinder	13(6)
Therapist Interactions		
	Support	22(14)
	Hinder	12(6)
Peer Interactions		
	Support	19(12)
	Hinder	1(1)
<i>Program Community & Culture</i>		
	Support	43(13)
	Hinder	7(6)
<i>Experiential Education & Adventures</i>		
	Support	32 (11)
	Hinder	1 (1)
<i>Program Components</i>		
Check Sheet		
	Support	4 (2)
	Hinder	6 (5)
Dating Policy		
	Support	7 (3)
	Hinder	7 (7)
Exercise		
	Support	9 (5)
	Hinder	0 (0)
Family Therapy & Workshop		
	Support	9 (4)
	Hinder	0 (0)

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Medication & Medical Management	Support	4 (3)
	Hinder	13 (6)
Groups	Support	8 (6)
	Hinder	9 (6)
Leap of Taste	Support	6 (5)
	Hinder	2 (2)
Life Skills	Support	14 (9)
	Hinder	3 (2)
Life Story	Support	8 (5)
	Hinder	2 (2)
Phases of the Program	Support	7 (5)
	Hinder	(1)
Total Incidents		327
	Support	248 (76%)
	Hinder	79 (24%)

Participation rate per incident. Participation rate is one method for establishing credibility of categories. Participation rate is calculated by determining the number of participants who cited a specific incident that was coded by a particular category or theme. The participation rate is divided by the total number of participants, which in this study is seventeen (Butterfield et al., 2005). Borgen and Amundson (1984) established the rate of 25% participation for a category to be considered valid. Table 4.2 shows the participation rate for each critical incident and the bold indicates categories that met or exceeded 25%, indicating credibility of an incident.

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Table 4.2

Participation Rate to Determine Validity

CRITICAL INCIDENTS		PARTICIPATION RATE %
<i>Interpersonal Interactions</i>		
<i>Mentor Interactions</i>		
	Support	82%
	Hinder	35%
<i>Therapist Interactions</i>		
	Support	82%
	Hinder	35%
<i>Peer Interactions</i>		
	Support	70%
	Hinder	.5%
<i>Program Community & Culture</i>		
	Support	76%
	Hinder	35%
<i>Adventures/Experiential Education</i>		
	Support	65%
	Hinder	.5%
<i>Program Components</i>		
<i>Check Sheet</i>		
	Support	1%
	Hinder	29%
<i>Dating Policy</i>		
	Support	17%
	Hinder	41%
<i>Exercise</i>		
	Support	29%
	Hinder	0%
<i>Family Therapy & Workshop</i>		
	Support	23%
	Hinder	0%
<i>Medication & Medical Management</i>		
	Support	17%

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	Hinder	35%
Groups		
	Support	35%
	Hinder	35%
Leap of Taste		
	Support	29%
	Hinder	12%
Life Skills		
	Support	52%
	Hinder	12%
Life Story		
	Support	29%
	Hinder	12%
Phases of the Program		
	Support	29%
	Hinder	.5%

The participation rates as shown in Table 4.2 support the highest participation rate which were previously described and are:

- Interpersonal Interactions;
- Community and Culture;
- Experiential Education and Adventure
- Program Components

Table 4.3 presents the original CIT framework and the adaptation applied and used in this research.

Table 4.3
Framework of Antecedents, Incidents, and Outcomes Used in This Dissertation

Original Critical Incident Labels	Adaptation
Antecedent to critical incident	Best understood as how the alumni experienced life prior to treatment.
Critical Incidents	Critical incidents of participant experience that was significant. How alumni made meaning of and talked about experiences while enrolled with the program.
Positive and Negative	What supported or hindered growth and change?
Outcome to critical incident	How alumni currently experience and describe their life post treatment.

Note: Based on concepts outlined in Butterfield et al. (2005).

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Antecedents and Outcomes

The section that follows describes the antecedents that led to treatment and the outcomes experienced by participants one to five years post treatment, depending on the year they were enrolled with the program. Antecedents and outcomes have been combined in this section in order to directly compare and contrast pre and post treatment statements. All of the alumni interviewed engaged in therapy or treatment programs prior to the young adult transition program and often from an early age. Often, a wilderness therapy program was the initial catalyst for change and readiness for a transition program. The stories told about life experiences prior to treatment describe anxiety, depression, isolation, multiple diagnoses and mis-diagnoses, trauma, lack of insight, suicidal ideation or attempts, substance abuse, and dis-connection with self, others and community. In contrast, stories about life following treatment describe connection, support, perseverance, and insight regarding life challenges. Alum P13 described the antecedent leading up to treatment and the combination of personal challenges within the dynamics of the family system:

I'd been seeing mostly individual therapists since about the age of 12. I've seen counselors and psychologists, psychiatrists for OCD. I think that was really the focus, but there was just a lot of poor communication at home with my parents, a lot of anger management issues, just very little understanding of emotions on my behalf and I think everyone in my family.

In contrast to the antecedent is the outcome Alum P13 shared what life is like for them in the present moment:

I am doing really well now. I live in an apartment-style dorm on campus . . . I have three wonderful roommates. I'm very happy. I'm just enrolling as a full time student. I have had academic success in the past two terms. I've gotten my first real life job and held it for three months now.

Alum P5 shared how the skills that they learned in treatment are being applied in their current life with the recognition that life still presents challenges. Prior to treatment, Alum P5 “was struggling with bulimia and severe depression, severe anxiety, all the DSMs [Diagnostic and Statistical Manual of Mental Disorders].” Following treatment Alum P5 stated:

I am working on my associates for human services and then I'm going to get my DSW, MSW and then I want to become a DBT [Dialectical Behavior Therapy] therapist. I'm struggling a lot right now. I am kind of in my depression and it sucks and I hate it. At the same time prior to treatment I wouldn't fight and I'm fighting right now. I have good resources, I have good friends, I have good support and I'm sure that we'll talk about this later, but Dragonfly helped with that. It really, really did.

P16 shared that prior to treatment they “had a therapist before going to Wilderness Therapy, but some of it wasn't really helping and so I had a lot of depression and anxiety and I was getting into a lot of trouble.” In contrast, P16

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describes how the experience at the transition program supported job skills and improved familial relationships: “I’ve been working for about a year and six months now. Dragonfly instilled in me a lot of confidence in getting a job . . . and having a better relationship with my family.”

Alum P9 described the long journey of treatment and showed that it can often take many treatment placements and challenging life lessons before reaching a calmer more stable stage of life. The story of P9 reinforces the fact that treatment is not a linear process and in this case, the treatment journey started before the young adult transition program and continued well beyond.

I was in three residential treatments before Dragonfly. They were all focused on mental health. I was there as an adolescent before I turned 18 and then Dragonfly was a follow up program to that. I was extremely depressed and suicidal. I had several suicide attempts. I was on drugs. I was on crystal meth since I was 16. I had a lot of discontent between my family and I. We would fight a lot. I had aggression issues; I had an assault charge when I was younger. I’ve stolen money from my parents. I was just really bad news when I was a young kid.

About life following treatment, P9 shared:

I’m doing better. I relapsed about a year ago. I ended up going to rehab about a year ago, followed by two outpatients, which I didn’t complete and then another round of rehab in March. I’m currently in sober living and doing well.

The narratives above are contrasted with the OQ-45.2 score of participants, which resulted in a mean score of 52 and a median of 46. These scores reflect that clinical symptoms have remained below the clinical cutoff of 64 for participants in this study. The mean OQ-45.2 score demonstrates sustained benefit beyond treatment for these 17 participants.

Incidents That Support or Hinder Growth and Change

When participants were asked about incidents that supported or hindered the process around growth and change, it was evident that the time following discharge from treatment had allowed for meaning making and insight. It appeared that the alumni had time to reflect upon the experience as a whole as well as on individual incidents, interactions, or significant moments and this allowed for increased awareness and the ability to apply meaning to an expanded and broader perspective. What emerged from the analysis of the data was a pattern of responses that revolved around four main themes and the incidents appeared as intermediary steps between what they described as critical and significant and the resultant outcomes or behaviors as described in their lives beyond treatment. Participants often made statements that fit into several of the categories within the coding structure. There is overlap and symbiosis of the themes within the categories, further supporting the importance of the critical incidents: interpersonal interactions, community and culture, experiential

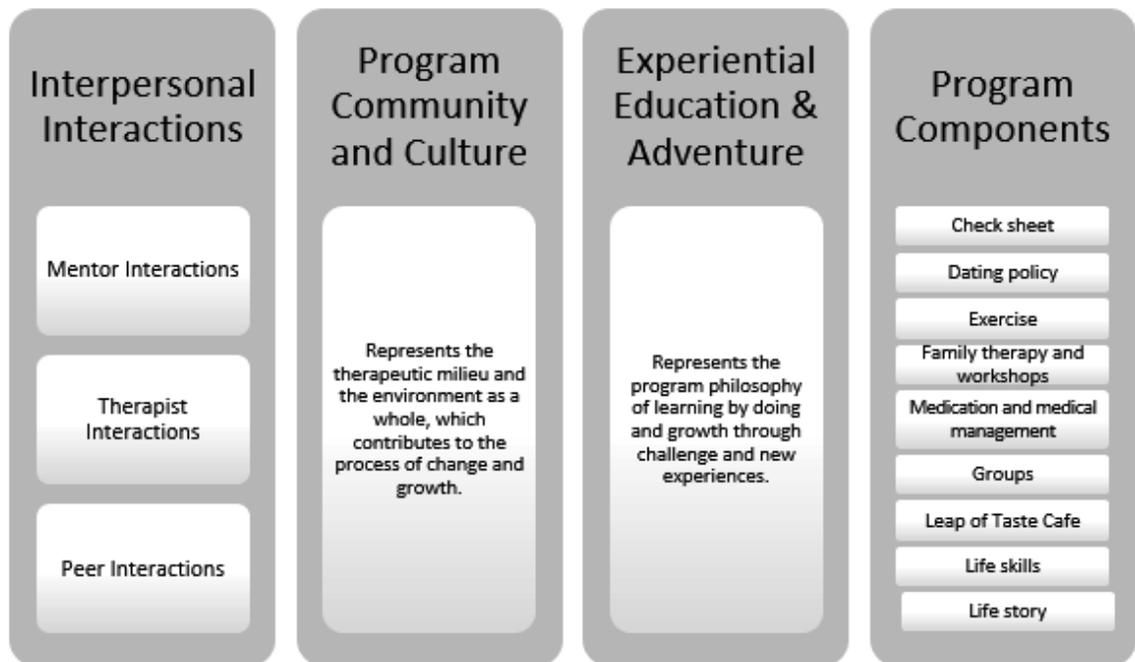
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education and adventure, and individualized program components. Figure 4.3 below provides an overview of the four main categories of critical incidents with subthemes listed below.

Figure 4.3. Critical incidents and subthemes.

Interpersonal interactions. Interpersonal interactions between participants and a mentor, therapist, or peer, account for 34% of the total 327 incidents (110 of the 327 total). Each of these interpersonal categories are described next to uncover the nature and quality of these types of relationships.

Mentor interactions. Within the supporting incidents of mentor interactions, the most frequently reported themes are of connection, support, boundaries, fun, working alongside the student, and being treated equally. Mentors are the direct care or line staff within the program. They have the most direct contact with a student on a daily basis and they are responsible for the daily structure, accountability, and support. Mentors work with the therapists to support the master treatment plan and help the student to apply the treatment plan to their day-to-day life. The collaboration between mentor and therapist is crucial in the success of the program and in its support of the student.



Alum P8 spoke about the confidence developed through the work with Mentor X as they were encouraged to engage outside of the program and look for work.

Mentor X would help you with finding a job that would suit you and preparing for the job. He also instilled some confidence in me or helped me find my own confidence for things outside of Dragonfly, and that was very helpful.

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Another alum, P12, talked about how helpful it was to have a mentor do things with her: “she and I went to exercises classes . . . together . . . She would get me moving and that was helpful.”

In the interview with Alum P3, one sees the importance of the mentor-student relationship and connection in conjunction with boundaries and genuine care.

I felt like a human that's with an authoritative friend . . . She knows when it's appropriate to share personal things. . . . I do know a lot about Mentor B, but she's very good, very good at separating her life from yours . . . from the little I know, she's been through a lot too and just enough so she can empathize, but not enough so that I feel like she's projecting. . . I like her happiness and enthusiasm, and I feel like she genuinely cares about you. And she's smart too.

Alum P9 spoke about developing relationships through the adventure trips and the type of personality traits within a mentor that they found supportive:

She was always very supportive. She was kind of quirky and I really liked that. She was always really upbeat . . . Trips allowed us to connect with the mentors on a more personal level. Because a lot of them were younger like us, so being able to connect with somebody similar to your own age that has maybe had similar experiences to you was really helpful. It helped us like a bonus point like you just don't have a therapist, but you also have somebody who has maybe been through the same things with you, who has a little bit more experience than you but maybe help.

As with several other participants, Alum P14 talked about how important the support and suspension of judgment is to the relationship: “The mentors, for the most part, they're really great. They were very supportive and the less judgmental they were, it tended to be the better the mentor.”

Alum P8 expanded on an incident in which they experienced support from a mentor and shares key elements of that interaction that made it a significant experience:

She listened a lot and she wasn't trying to fix me. She wasn't telling me what I needed to do to get fixed. And that's what I needed at the time and I think she saw that. I think if I had gone and asked her what can you give me to help, I'm sure she would have had suggestions, but I think what I needed at that time was somebody who would listen and understand and I think we connected on that because it didn't feel like there was any judgment. She just felt sad for what I was going through and that alone was very supportive. So just the understanding of what somebody is going through without trying to fix them I found was very much what I needed at the time.

Hindering incidents in mentor and student interactions were also referenced. The most frequently reported were inappropriate public comments, the mentor

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being too authoritative, and having lack of trust in the student.

Alum P3 described an incident of feeling embarrassed by the mentor in a public setting. This interaction impacted the level of trust and rapport between student and mentor.

We get to the counter and I have my credit card, but she is with me, my mentor. So the woman at the cash register asks, because there are two adults standing in front of her, "are you paying for this or is she?" And she refers to my mentor. And I said, "I am." And mentor goes and says, "She isn't paying for it, her mother is."

The theme of trust was spoken of again by Alum P4 who did not feel trusted by the mentor; this hindered the relationship. "It feels like the trust piece wasn't there and that like threw me off after that point to where I could not—I don't know, I couldn't take her word for anything really."

Participants highlight the importance of all staff maintaining a balance between structure, accountability, and freedom and supporting students to step into an adult role. This is a skill that not all mentors have found the balance for, as evidenced by Alum P14. This is another example of how students don't like to be told what to do and how the style of communication and engagement is critical. Alum P14 said:

It seems like Mentor Y had a very strong idea of how things should be even if it wasn't that way. It was kind of authoritarian . . . she was perfectly nice for the most part, but she was very her way or the highway and that did not work with me at all. Because I'm an adult and I wasn't there to be told what to do, I was there to be guided on what to do.

Therapist interactions. The therapists at the program work with the student on an individual basis to provide therapy, develop the master treatment plan, and to routinely assess progress and whether the student is engaged and benefiting from the services provided. The therapist is the primary contact and source of communication for a student's family and referring professional. The master treatment plan includes goals around clinical diagnoses as well as goals in the areas of life skills, education, fitness, vocation and recreation. The therapists typically meet with a student once per week, facilitate family therapy every other week and are in the milieu and run a variety of groups.

The most frequently reported themes within supporting incidents of interactions between therapist and student were therapists' ability to challenge or push the student; the student feeling like the therapist was a good fit for them; the therapist being empathetic and compassionate; and the student feeling accepted and not seen as a patient.

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The experience, communication style and ability of a therapist to maintain rapport and also challenge the student were discussed by many of the alum in the interviews. A particularly poignant paragraph comes from Alum P6, in which they speak about the long lasting impact of being challenged beyond what they believed they were capable.

Therapist X was great. She pushed me. She pushed me hard and I'm glad she did because I'd probably not be in the position I'm in now. I got into some rough areas when I was out there, some patches where I wanted to just give up and it was too hard and I'm glad I had the two people, my mentor and her to push me to try harder.

Even though some alum disliked the dating policy, several, like Alum P9 were able to see the benefits, particularly as they worked with their therapist on coping strategies and specific areas of challenge in their life.

I remember talking to my therapist and I had requested to date this person and he said that I needed to be working on myself and eventually I got that idea through my head. It was months later after I had already left Dragonfly that that stuck with me, the idea that you need to be working on yourself before you can be in any sort of relationship. And that really helped me through several tough relationships that I had afterwards, just the idea of putting yourself first and not letting yourself be bullied or bulldozed over. I did really appreciate working with him on that.

The willingness of a therapist or mentor to make themselves available and for a student to feel genuine care and concern, not simply a means to a paycheck, were common areas discussed in the interviews. P13 captured the essence of care, feeling heard and that someone would follow up with them:

I think all the therapists I've worked with at Dragonfly and all the mentors were always really caring. Even if they were in the middle of doing one thing, they'd find you afterwards. Some understood certain struggles better than others, of course, but I think they all really listened when I spoke to them, which is great. So again, their availability or the way they made themselves available was really helpful.

Alum P3 nicely summarized the importance and powerful therapeutic impact of positive relationships and connection between therapist and students by stating "I felt accepted as a human and not a patient, and therefore increased my confidence. They made me the functional person who I am today."

The most frequently reported themes within hindering incidents of interactions with a therapist, were most commonly described as the relationship not being a good fit, the student not liking how a situation was handled, or wanting more sessions than were being offered.

Alum P3 articulated the self-awareness, sensitivity, and perhaps shame

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experienced by students when faced with talking about consequences for an action. The quote below reflects how communication styles impact the delivery of a consequence.

I was there because I was breaking boundaries with guys and just not really getting it. And I think the therapy the way that they approached—or my therapists and mentors approached it—was negative to me. It just made me feel like an outcast I guess. I got punished for it, I don't know why I wouldn't get punished for it, but just the way that they approached it made me feel not very good.

As seen in the interviews with Alums P3 and P8, communication style and technique and skill that comes with experience is critical to developing therapeutic rapport and effectiveness.

I didn't get along with therapist because I think she is like fresh off the boat and she repeats everything you say back to you, with kind of a condescending tone. In a matter that reflects that she is hearing but not listening. I would say, "I feel uncomfortable speaking around you because I don't feel recognized as human." And I'd been using all my proper communication techniques and then she kind of repeat back to you, "I hear you hate me and that you don't want to work with me."

Alum P8 experienced positive regard for their second program therapist yet found the lack of experience and the therapist's youth to be a hindrance to their therapeutic process.

I advocated for myself to go to a different therapist. He seemed much better equipped. He had a much more broad open mind, deeper thinking, connecting more dots that kind of thing, less conventional, by the book way of thinking. But I don't think he had the experience. He's a much younger guy.

Peer interactions. Interpersonal interactions between student, mentors and therapists have been described as an instrumental component for the process of change. Another area of critical incidents as reported by alumni was the peer-to-peer interaction. In this third category of interpersonal interactions—peer-to-peer interactions—the most frequently reported themes of supporting incidents with peers, were friendship, bonding, and the support received from peers. Of interest was the recognition and appreciation of a shared therapeutic language that included the practice and importance of learning to be in relation with others.

The category of peer-to-peer interactions, as with other categories, has themes that overlap in other areas of critical incidents. This begins to paint the picture of the importance of the larger context of community and environment or culture. The thread found throughout all categories is the importance of being in relationship with self, others, and community. Prior to treatment, alum often describe themselves as isolated and disconnected from community and peers.

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Alum P8 expressed the value of the milieu and peer connection and how this helped with social anxiety:

I had a lot of social anxiety. I didn't grow up being very social due to my anxieties and other things, so being put in that environment with a lot of my peers; I think that probably is where I gained the most benefit at Dragonfly.

Alum P1 also shared how living with others increased their social skills and awareness of others:

At Dragonfly I had to learn how to cope with living with others and accommodating the feelings of others and learning to be friends with people. That was big for me, and I think I'm now much better at the whole social thing, although I do still like my space.

There was only one hindering incident reported in the peer-to-peer interaction and this addressed the level of commitment to treatment by other peers and how this impacted the individual. Alum P11 found it challenging and detrimental to their treatment when students arrived that didn't want to engage in what the program offered. "Some students coming in had the attitude of 'I'm going to break every rule in the book and I don't care'".

Often referenced in life post program was the close connection that many alums maintained amongst one another beyond treatment. They spoke of long lasting connections and utilizing these relationships when they are in need of support.

Program community and culture. The overarching therapeutic milieu, or what was most often referenced as the "Dragonfly community and culture," accounts for 16% (50) of the total 317 incidents (50 of the 317 total).

The most frequently reported supportive incidents within the category of community and culture were about flexibility displayed by the program, the importance of group living, and the high level of support through connection and community that was experienced by students.

The following quote may not appear to be a major incident, however it was a salient moment for Alum P1, and reflects both flexibility from the mentor as well as a sense of community and camaraderie:

I remember one night when we were watching the season one finale, one of the staff came in and said it was time to turn off the TV and we all turned around on her and went, "Veronica is trapped in a refrigerator with a murderer sitting on top of her." And the staff member just sat down and we all finished the episode together.

Alum P15 stated: "I liked the whole environment. I liked how we weren't in a big facility." The program is located in a residential neighborhood and

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students live in houses without identifying signage that it is a program. Alum P14 remarked on the level of freedom afforded students and how this contributes to a healthy lifestyle:

I do think that Dragonfly gave us a fair amount of freedom. Dragonfly was really positive that way. It provided like positive outlets . . . in terms of things to do to have fun rather than build unhealthy activities.

Alum P6 captured the feeling of being accepted and supported as they gather skills to live independently. This speaks to an environment that enables participants to engage in the therapeutic and maturation process.

If I had to say something about that nature I'd say that Dragonfly, they welcome you with open arms, they're more than happy to help you along the way until you feel that you are ready to transition into the new world—or hell of a world.

Alum P5 addressed the feeling of emotional safety and the support in addressing conflict that inevitably arises:

The emotional safety that I felt there—and I guess what I mean by that is, if I felt like I had an issue with one of the girls, I could address it with one of the staff or them and the staff and like the staff was so great. Oh my God, I love the staff. And just knowing I was in an environment where I wouldn't feel judged for something that I felt.

Alum P5 maintained friendships built within the program beyond treatment and stated: “The key thing—and my friends and I talk about this—the key thing that we loved and still miss about Dragonfly is the community that was built.”

On the opposite end, the most frequently reported hindering incident within the program community and culture, was feeling they were being treated as children. For all new students that enroll there is a 50-hour requirement of volunteer work. Some students, like Alum P10, this was internalized in a negative manner; they felt they were “being infantilized by being told that I'm not fit to interact with the community, so I have to spend 50 hours doing meaningless work that helps nobody.” Another alum, P8, said “there was something about it that made you feel like almost they expect you to act like a child and they expect you to be immature. I think a lot of people acted up at times because of that.”

Experiential education and adventure. Experiential education and adventure had a participation rate of 65%, with all but one incident falling in the supportive category.

The adventure programming was consistently and positively spoken of in the interviews. The most frequently reported supportive incidents were the outdoor and wilderness trips, the ability to explore new areas and have new experiences, the international travel, and the community that was created through adventures.

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Alum P13 discussed the therapeutic benefit of new experiences and challenging oneself outside their comfort zone:

The overarching theme of just new experiences, any sort of new things I did with Dragonfly, whether it was the rafting trips that I went on with them or skiing, even horseback riding, which I hadn't really done. Those were all exciting and overcoming the little challenges that I found helpful, especially with OCD. I've had a lot of fear with trying new things or leaving the comfort zone, which I'm sure a lot of the students do, so those new things were good.

Since 2010, the program has offered a 25-day trip to Cambodia. This is an earned trip and is service based. Alum P3 shared the value of international travel and of this particular experience:

Before I went to Cambodia, I'd always taken education as something I'm required to do and also just because what else am I going to do? But going to Cambodia, working with students at the Kravanh Bright Future Center, I learned that education is really a privilege, and those girls there barely get to do it and so what the fuck am I doing squandering all my opportunities?

Again, the theme of community, relationships and getting outside of self and personal challenges is seen. This time it is seen within the context of adventures and having the courage to engage in a novel, and unknown experience. Alum P9 summarized the therapeutic gains made through rafting:

One of my happiest memories is going on a rafting trip that I went to with Dragonfly, which was absolutely amazing. It really helped me with my team building skills and character building, being able to work with other people. Because before it was all about me, like I was very selfish. I didn't want to work with people. I didn't work in teams. I was lazy and never put the work in. It really helped me with that, being able to be a team player and being able to implement those skills into real life, such as employment, any kind of sports teams I want to be a part of, any type of friendships I have—it's just really helped me in that way. And it was just a wonderful experience.

Alum P4 spoke to the relational dynamic with mentors and this provides an example of the interpersonal relationships category and the various avenues in which building and developing relationships occur: “And like getting to spend more time with mentors on a different level, like in a different scene was really fun and really helpful. Just because it made our relationships that much stronger.”

There was one hindering incident in this category, discussed by Alum P2: it revolved around poor planning and how that impacts the outcome and experience of a trip:

We went on a canoeing trip where they rented a whole bunch of canoes. Well it turns out that the canoes were not allowed on the river because it's white

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water. I love whitewater because you can balance over it and you'll be fine, but there's just something different about canoeing and especially over really choppy waters and people were over turning. I remember like three or four canoes just that day overturned. It wasn't well researched or planned.

Program components. A variety of the program components were discussed in the interviews and all combined account for 39% of the total 317 incidents (124 of the 317 total). The following section is broken into each area of the program that was reported upon; each section starts with a table that reflects the critical incidents, number of incidents reported and how often alumni referenced the incident. The program components are not listed in order of importance or number of incidents. The following program components were mentioned: check sheet, dating policy; exercise; family therapy and workshop; medication and medical management, groups; Leap of Taste; life skills; and, the life story. Taken individually, most of the program components do not have a substantial number of incidents, however every program has unique services, systems, and interventions and these all contribute to the overall community and culture of a program. It remains important to include the findings.

Check sheet. Students at the program earn weekly spending money. This is done through a process called the check sheet, which contains the structure and expectations for the day—getting out of bed on time, going to the gym, completing chores, engaging in groups and attending therapy sessions. The most frequently reported supporting incidents were that the check sheet provided structure and accountability. Alum P15 discussed the value of the check sheet: “I liked the structure of it all and how there was a schedule. The check sheet really helped me, just being able to visualize my day beforehand and having to follow through with that.”

Alum P5 talked about how the check sheet fostered a sense of personal accountability:

The check sheet was extremely smart. That was very smart because it is technically you holding yourself accountable. It's like an interdependent accountability kind of thing. Because long term it's very difficult for me to hold myself accountable, so to have something like that there in a program that actually works, is really great.

A number of incidents that hindered were raised in the discussion around the check sheet. It was reported that the check sheets seemed childish and created additional stress for students. Alum P14 understood the intent behind the check sheet and also shared how it made them feel: “I understand that some people probably really did need that structure for it; but it made me feel a little bit like a kindergartener, like getting signed off on some things every day.”

Alum P13 discussed the additional anxiety check sheet created in juggling the daily routine of getting out the door and having to wait for a mentor to sign off on the sheet:

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It did cause me, now that I think about it, some anxiety, but a lot of things do. I do remember just waiting around, getting really angry because a staff member wasn't there to look at chores and I was going to miss the bus to school so I just said, "Whatever . . . screw it."

Dating policy. The program has a dating policy that asks students in Phase I to not date and to focus on themselves and the areas of challenge that brought them into treatment. In Phase II, if a student would like to date, there is a petition process with the therapist in order to support healthy and safe relationships. The most frequently reported supporting incidents were about the acknowledgment that relationships can be distracting and that the participants liked some separation between men and women, such as living in separate houses and having some single sex groups.

Alum P5 spoke about the value of learning to be with women and learning to develop healthy, non-romantic relationships:

I do think it was really important to have the men and women be separated. Because for me one of the things that was good for me was the relationship I formed with women. So being in a house with only women and learning how to be friends with women again that was important for me, without the distraction. I mean, I'm attracted to women too, but I just needed to find that friendship piece and to be away from, say, gendered men, that really helped in redefining who I was as a woman.

Alum P12 referenced the distraction of relationships: "I feel like it's really distracting to have the opposite sex there if you're straight and I still definitely use it as a distraction, unfortunately, but it's helpful. I think it's like a helpful boundary."

Alum P9 shared how they worked with their therapist on relationship challenges: "He helped me work on my boundaries a lot. I had had a girlfriend when I was there and he really helped me working on saying 'no' to people, standing up for myself."

There were equal numbers of incidents reported as supportive and hindering in the dating category; however, there were more sources within the hindering category. There was only one incident in each theme, as seen in Table 4.10. Below are some examples of areas that the participants found to hinder. Alum P13 discussed the detriment of how much time mentors spend managing the supervision of relationships:

A lot of staff energy was spent on trying to make sure that people weren't holding hands or a guy and a girl weren't hanging out together which that did kind of . . . I mean, a lot of relationships issues did take up time . . . there were certain conflicts that I thought didn't really have to be conflicts that time was being spent on, we're calling groups for them.

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Alum P12 shared that it felt like if a relationship boundary was broken that the program viewed it as a major regression in their progress through the program:

When boundaries were broken, it was like, “oh well, that’s a backslide in your progress.” That I think is bullshit. I think yes, it’s important to focus on yourself, but if you— I mean, honestly I don’t think it’s great for you to be having sex in a cemetery, that’s not cute or whatever. That’s what people would do, but I don’t necessarily think—unless you have a sex addiction, I don’t necessarily think that’s a backslide in your progress.

And Alum P5 felt that there needed to be more consistent and effective consequences given for students that consistently broke the relationship boundary:

I don’t think that it needs to be made as big of a deal as it was made and if that is the case, then there needs to be different or more consistent consequences. Because there were people who would consistently break those boundaries and it never stopped and it was like a ripple effect. And it was so annoying when they were given so much shit for it and yet they weren’t really given concrete consequences to make them stop.

This research was the catalyst for further evaluation and change in several programmatic areas. The dating policy was one such example.

Exercise. Exercise is built into the program and tracked on the check sheet. The expectation is that students work to find exercise that they enjoy. Daily trips to the gym are offered along with a variety of classes that are run by the fitness and nutrition director. Students are encouraged to access classes in the community, such as yoga, swimming, dance classes, cross-fit and the like. Surprisingly, there were no hindering incidents mentioned in this area. The most frequently discussed supporting incidents were that the daily structure created a habit of exercise and it was good for health and wellness.

Alum P6 shared: “I have definitely carried exercise forward and it’s something that I focus on. I definitely don’t work out as much as I did at Dragonfly, but it was really nice while I was there.” Alum P9 offered that exercise helped regulate sleep and stated that “by going to the gym in the morning and having to get up on time was really helpful, I had to regulate my sleep.” And Alum P3 stated, “I learned that vigorous exercise is one of my best coping skills.”

Family therapy and workshop. All parents receive individual sessions with parent coach professionals and are asked to participate in family therapy conference calls and a minimum of one family workshop per year. The program offers three family workshops throughout the year.

There were no hindering incidents reported in this category. Of the supporting incidents there were a range of themes that included feeling supported

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with difficult family dynamics, improved communication, and the value of the family workshop. Alum P11 stated that the therapist “knew how to set up family phone calls and how to push me in a way in which I would not digress.” Alum P6 shared: “The skill building of learning how to talk with your loved ones and everything that we did there, was very helpful to let go of what we had done in the past to hurt any family members.” And Alum P4 spoke to the effectiveness and importance of the family workshop: “Family weekends were extremely, extremely helpful, 100%. That goes in the positive column. Everyone got on the same page, was very much on the same page, even if there were a lot of disagreements through my time there.”

Medication and medical management. Approximately 90% of program participants arrive on medication. The most frequently reported supportive incidents were in the area of medication reduction and an increased understanding of medication side effects. Alum P1 stated:

That was always part of the issue, I couldn't tell the doctors what differences I had noticed because I wasn't paying attention to how my mood was changing or my life. I didn't really care that much about the medications up until Dragonfly. But I did notice when they took me off the one that was actually doing something for me. I got really cranky. I went and yelled at someone, which is very, very unusual for me.

Alum P14 talked about arriving at the program with a lot of prescription medications and working with the psychiatrist to reduce and find out which medications were actually effective: “While I was at Dragonfly they took me off one at a time until I was down to just one. There was only one that was actually doing anything for me, and I had been on like eight before that.”

Medication and medical management had a higher number of hindering incidents than supporting. The themes ran mostly to communication style, not having quick enough access to an MD, and feeling that the MD's had an “old school” approach. Alum P3 shared their frustration about confidentiality and perhaps not feeling heard around a particular topic: “‘No, you just need diet and exercise.’ . . . They broke the patient-doctor confidentiality I can't even tell you how many times. They told my parents stuff that was confidential.”

Alum P10 felt challenged that the MDs were not addressing a situation with medication management and suggested that a return to wilderness might be more effective:

They were completely incompetent. They did not know anything about medications. They had heard of half the medications I've been on. And when I said that I was really depressed, they suggested going to wilderness as a solution, when what I really needed was my meds.

And Alum P11 felt that the program did not properly acknowledge or

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accommodate for an injury and stated: “They acted as if I didn’t have a cast on. They just made me do everything, even though we had three pages from the doctor that no you can’t do this, this and this.”

Groups. Groups range from therapeutic, to life skills, to recreational, and vocational. Students work with the therapist and mentor to choose the most relevant groups based on their particular areas of challenge and to create an individualized weekly schedule. Among supportive incidents, the most frequently reported themes were about the variety of groups offered and the smaller treatment team group. Alum P4 spoke to the importance of interpersonal interactions within the context of groups: “I made really good guy friends and had more of a support system; I found it to be really helpful. Especially when we were in therapeutic groups, that was something that I really enjoyed.”

Alum P16 stated: “*Groups really helped me . . . just learning about different things and how I can deal with my emotions and to deal with confrontation and everything.*” Alum P10 shared: “*There was one group that we had that was good, it was about shame and resilience, but it was so good that there were like 20 people in the group, which is crazy.*”

In this category, the supportive and hindering incidents were almost evenly split. Of the hindering incidents the most frequently reported were around groups being poorly managed, and attending groups that didn’t feel relevant for that particular individual. Alum P10 felt that women’s group “was basically like a bitch fest where some girls would complain about other girls” while Alum P4 said that the “groups that I didn’t think were helpful were run by people that I just didn’t have— this sounds really rude—but I didn’t have a lot of respect for.” Alum P14 spoke about the feeling of redundancy and perhaps being “over therapized”:

I think sometimes there were so many groups that it got almost a little repetitive, especially when you’ve been there for a while. It kind of makes sense for many people to go, but I think I got a little therapied out near the end.

Program Café. By turning in a résumé and applying for a position at the program’s café, students work through the basic steps of obtaining a job with the security of knowing their mistakes are preparing them for future jobs. The most frequently reported supporting incidents revolved around increased confidence and this theme is reflected in this quote from Alum P16:

Getting to work at A Leap of Taste and being kind of an assistant chef with students, cooking for Leap of Taste, that actually was kind of my first job. It built a lot more confidence in me. And it really helped when I first got the job here . . . I had a lot more confidence.

Alum P14 shared how they started as a volunteer and then subsequently were hired on as an employee:

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I also worked at Leap of Taste. I started out as a volunteer and then they hired me on and I worked there I think for maybe like five, six months, I don't know. But that was really helpful. I got to make some money. I got to have some work experience at probably the hardest, most physically demanding job.

Alum P3 found that the experience contributed to emotional resilience and the ability to follow through on commitments:

It was also an important tool for me gaining like emotional resiliency. One thing for me that I've worked on a lot is following through with the commitments I make . . . I like that Leap of Taste has shorter hours usually shifts of three hours, which is good for people with anxiety because six-hour shifts are kind of overwhelming, especially at first. But the three-hour shift two or three times a week is enough to kind of build your confidence.

The primary theme in the hinder category was around the volunteer aspect of the training and not being financially compensated. Alum P10 shared their frustration in feeling taken advantage of:

I don't know if you guys still have the café. But they had like a program to train people how to run a café but what was happening is they weren't getting paid. You get trained in Starbucks, for example, but you get paid. It's not free labor and Dragonfly took a great advantage of its free labor.

Alum P12 also shared their anger with the volunteer component of Leap of Taste and the ultimate positive benefit:

At first it really pissed me off because I was like—I understand volunteering at a place where you're actually making a difference but volunteering for slave labor, it's like demeaning. But it was actually good for me.

Life skills. Life skills are woven throughout the structure of the program. Abilities within the multi-faceted area of life skills facilitate physical, mental, and emotional well-being for individuals. The most frequently reported supporting incidents in life skills was the social skills and increased independence that came about through a variety of interactions. Alum P3 felt particular accomplishment in the realms of cooking and stated:

I learned a lot of cooking skills. I thought I was a good cook before, but I learned so much about cooking and healthy cooking, and had so much fun participating in cooking and preparing family meals on like Tuesday afternoons. That was an important moment for me.

Alum P13 also commented on the area of cooking and shared that “preparing dinner for a group of people was impactful” and they “liked having that sense of purpose.” Alum P1 focused on the independent living skills and the skills that support the transition into being an adult:

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Learning to be an adult and take care of myself and wash my own dishes and do my own grocery shopping and clean my apartment and just generally navigate the little parts of adulthood that are part of everyday life. Cooking—I learned a little bit of cooking. That was good. So just transitioning from having lived with my parents and having lived with my stuff done for me to doing it myself, but with the support of people who could teach me how to do it.

While some participants found the component of life skills to foster a feeling of adulthood, other alumni found it to be too much as evidenced by this comment from Alum P10:

We had so much cleaning that they invented chores like sweeping the sidewalk. I mean, you're not supposed to sweep the sidewalk, that's not a thing. It was insane. Like once a week we'd be cleaning the inside of hanging lights. That seems really intense.

Life story. The life story is a therapeutic assignment in which the student writes their life story and shares the narrative with either the smaller treatment team or the community at large. The student works with the therapist as they write their life story and it provides an opportunity to understand the student in more depth and for the therapist to encourage the student to highlight areas of positive experiences along with the areas of challenge. Participants reported positive incidents in the areas of transparency, vulnerability and connection. Alum P17 talked about the process of sharing their life story and how this particular assignment “creates a close-knit community where they want everyone to intermingle.” Alum P11 spoke about the vulnerability and opening up more: “It really did help because I was able to admit more, I was able to sort of put more pieces into the puzzle of the big unknown.” Alum P3 found this assignment to be a catalyst for change:

But that was definitely a turning point for me because I feel like I had no more secrets and I felt more connected with my fellow people and invested in the community. That was a huge turning point for me. And the positive reactions I saw from my peers were just very empowering. That was definitely kind of a changing moment.

Of the hindering incidents there was one participant, Alum P2, who felt they were not emotionally ready or prepared to share their story:

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So basically you had to stand up during one of the family dinners or whatever it was, or a gathering, and read this life story out loud. And there were quite a few things at that point in my life that I was still getting over and dealing with and honestly I felt like it was quite a personal hindrance that I had to talk about it. The first thing they make you do the life story like within the first couple of weeks you're there if not the first week you're there. And I felt like I wasn't ready to open up and it wasn't fair to me that I had to. I don't know these people, I don't trust these people, why should I be telling them all my personal deep dark secrets, you know?

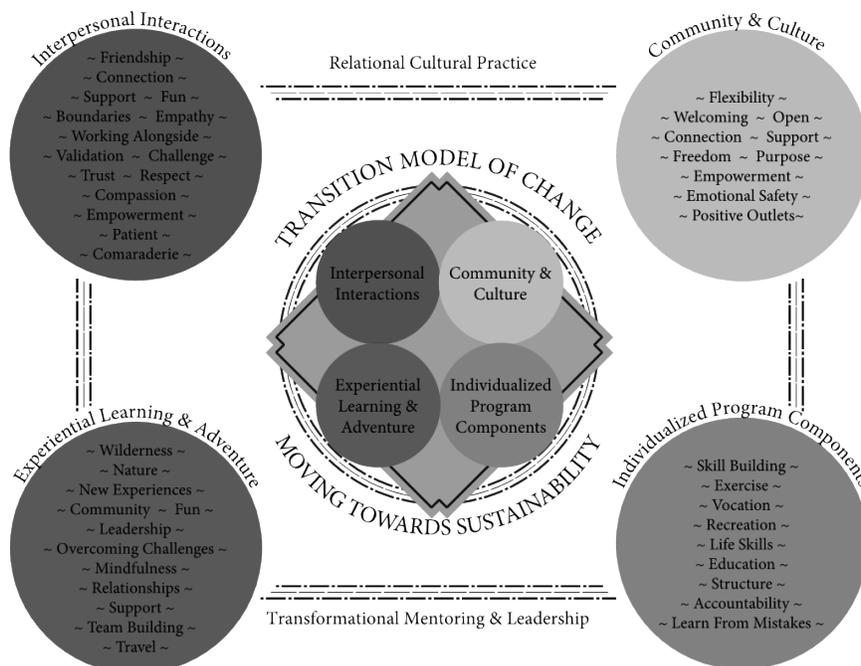
Discussion

Significant Findings

The stories from participants increased understanding of what creates an environment conducive to growth and change, and of the key factors that support emerging adults (Arnett, 2004) through this developmental transition. By analyzing and incorporating both supporting and hindering incidents, one better understands what participants find the most valuable within a therapeutic milieu as they work towards a sustainable lifestyle beyond treatment. The overarching themes that emerged as critical were: interpersonal interactions; community and culture; experiential education and adventure; and, individualized program components

Figure 5.1 below shows the interconnectedness and importance of these four themes.

Figure 5.1. Transition model of change.



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The visual model provides an additional means to explain the participants' perspectives and an interpretation of what is critical to include within a transition model for young adults. The words found within the large circles in Figure 5.1 are direct quotes from interviews, for it is from the voices of alumni that meaning emerged.

The following sections describe and examine the four most significant factors that were identified by the participants in this study, and relates these to the existing literature.

Interpersonal interactions. A half-century of psychotherapy research has shown that the quality of the therapeutic alliance is a predictor of treatment success and this finding has been evident across a wide range of treatment modalities (Alexander & Luborsky, 1986; Horvath & Greenberg, 1994; Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Orlinsky, Grawe, & Parks, 1994). A related finding is that poor outcomes show greater evidence of negative interpersonal process—that is, hostile interactions between therapist and participant (Safran & Muran, 2000). These studies, which include both qualitative and quantitative methodologies, corroborate the findings of this study. The interpersonal interactions between participant and therapist, mentors and peers, were referenced the most often in the interviews and directly impacted participants' experiences of the program.

Valuable information is learned from both the supporting and hindering descriptors. The insight offered from alumni reinforces the benefit of continually incorporating participant voice by creating structure for formative and summative feedback regarding therapeutic and mentor relationships. An example of this structure is a form of progress monitoring of therapeutic alliance such as the Session Rating Scales (SRS) developed by Johnson, Miller, and Duncan (2000). Research shows that “clients’ ratings of the alliance are far more predictive of improvement than the type of intervention or the therapist’s ratings of the alliance” (Duncan & Miller, 2008, p. 60), and this research further reinforces the need to elicit feedback directly from the participant on a routine basis.

In addition, the findings related to the quality of interpersonal interactions support the tenets of Relational-Cultural Therapy and its practice (Jordan, 2000; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991; J. B. Miller, 1976) that views high quality connection and relationship as a primary site of growth. Participants in this study reported that social influences and interpersonal interactions led to new approaches, values, and attitudes about engaging in the world and a better understanding of how to work through conflict within relationship instead of engaging in avoidance. The practice and value of working through the minutia of everyday interactions within an environment of authenticity, respect, and genuine care cannot be underestimated within a treatment milieu. Jordan (2000) suggests, in the context of relational cultural theory, that issues of power imbalance and oppression within a therapeutic context can create division, anger, disempowerment, depression, shame, and disconnection. When a clinician or program explores therapeutic interventions for a student, importance needs to

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be placed on mitigating the power differential and creating an environment of collaboration. In this study it was rare for a participant to describe a specific treatment modality that was considered critical to the experience and therapeutic process. Instead, alumni shared stories of personal connection that were empowering or incidents where an interaction hindered and therapeutic repair needed to occur for therapeutic momentum to remain intact.

Participants indicated that interpersonal connection played a substantial role in the healing process, personal growth and development of confidence. Although the significance of these connections is often assumed in therapeutic milieu programs, the students in this case study strongly supported the centrality of relationship in their development. The lives that alumni described prior to treatment reflected high levels of isolation, loneliness, and disconnection from self and others. To be included in a community, and to experience connection and belonging, can create change in profound and meaningful ways. The simple act of being accepted and feeling understood can have an impact on internal cognitive beliefs about oneself and the internal scripts can be shifted from negative dialogue to positive. Western culture emphasizes and celebrates independence, separation, and autonomy. Relational-Cultural Therapy (Jordan, 2000; Jordan et al., 1991; J. B. Miller, 1976) suggests that we need connection to flourish and that isolation is a source of suffering. The role of therapists and mentors becomes supporting development and change through socialization and connection. Participants in this study supported these tenets as they described how the health of these relationships directly impacted their outcomes. Participants gave equal mention to the therapist relationship and the mentor relationship. This is an important area for programs to give increased attention to, as mentors or line staff have the least training and the most direct interaction with program participants. Therapeutic skill has important intuitive and creative aspects that are difficult to teach yet are an imperative component that needs to be incorporated in training (Safran & Muran, 2000). The skill or ability with which any staff member engages a participant has potential for direct impact on treatment outcomes. Body language and nuance of tone and wording, can affect how a message is delivered. In the interviews, participants shared how they appreciated boundaries, being held accountable, and being challenged to dig deeper. The ability to absorb a conversation and engage in the therapeutic process was directly related to the quality of relationship and the way in which a message was delivered. It takes a great deal of skill, practice and self-awareness on the part of the practitioner to balance challenge and confrontation with support and rapport.

Community and culture.

Young adult programs have a challenging task to support the developmental tasks of emerging adulthood and to obtain equilibrium between support, structure, security and accountability while implementing it in a manner that feels empowering and supportive of individuation (Aquilino, 1997). One of the primary tasks for young adults working towards independence is self-governance, affirmed within the context of mutually validating relationships (Josselson, 1988).

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The program and the participants do not always find the balance and at times the program feels the need for increased structure and management, yet participants may feel they are treated as children or infantilized. This often comes back to interpersonal interactions and the skill with which a participant is approached. It can also relate to the participant's level of readiness to engage in the therapeutic process.

Experiential education and adventure. This theme rose to the surface as an integral component to the therapeutic and change process. The literature in adventure therapy and experiential education supports the findings in this area (Clem, Smith, & Richards, 2012; Gass, Gillis, & Russell, 2012; Koperski, Tucker, Lung, & Gass, 2015; Norton et al., 2014). Experiential education is defined as “challenge and experience followed by reflection leading to learning and growth (Association for Experiential Education, n.d., para. 1). The entire process of treatment is an example of experiential education. The Association for Experiential Education states:

Experiential education is a philosophy that informs many methodologies in which educators purposefully engage with learners in direct experience and focused reflection in order to increase knowledge, develop skills, clarify values, and develop people's capacity to contribute to their communities. (para. 2)

Adventure therapy (AT), on the other hand, is defined as the “prescriptive use of adventure activities by mental health professionals to kinesthetically engage clients on affective, behavioral, and cognitive levels” (Gass et al., 2012, p. 1). The foundation of the AT model includes putting participants in a unique physical and social environment in which they are given problem solving tasks or challenges that lead to a state of adaptive dissonance, where mastery of the task leads to learning and growth (Gass et al., 2012; Koperski et al., 2015).

New and challenging experiences in treatment can create opportunities to develop significant levels of trust (Koperski et al., 2015). In addition, shared experience combined with challenge, fun, and camaraderie, support the therapeutic alliance. If facilitated by an experienced practitioner these experiences can enhance interpersonal growth through building positive social interactions, stretching personal limits, and strengthening group cohesion.

The interpersonal connections and community created through this process is a catalyst for change. It has been shown that the skills learned in adventure therapy and through experiential education can be “useful and effective resources for creating positive affect and coping with stress outside of the therapeutic setting” (Koperski et al., 2015, p. 7).

It compels a more active participation in one's own treatment and increases responsibility for change while engaging the participants' internal motivation (Lung, Stauffer, & Alvarez, 2008). Additionally, adventures engage participants on physical, cognitive, and affective levels while at the same time it can be

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viewed as fun (Gass et al., 2012; Koperski et al., 2015; Schoel & Maizell, 2004).

Individualized program components. A variety of the individualized program components discussed by the participants of this study were at or above the 25% participation rate as suggested by Butterfield et al. (2005); these included: the check sheet, dating policy, exercise, medication and medical management, groups, the cafe (A Leap of Taste), and life skills. These components represent the minutia of the day-to-day structure and a means to achieving the larger goal of launching young adults into the world prepared to live a sustainable, healthy lifestyle. As evidenced by the range of services and structure of young adult NATSAP member programs, it is assumed that within each program there will be a variety of programmatic themes represented and unique to the structure of that particular program. However, within the framework of transition models for young adults, there is likely continuity of themes, such as Interpersonal Interactions, Community and Culture, Experiential Education/Adventure and Program Individualization, that exists based on the developmental age range and stage of life. The following section reviews the specific program components represented within Dragonfly Transitions:

The check-sheet. Based on the 29% participation rate within the hindering incidents and only 1% in the supportive, the check-sheet is an area to revisit in order to evaluate the effectiveness of the program's original intention. The intention was to create accountability and structure and a means to earn spending money based on performance, much like a paycheck. The check sheet also provides a means to concretely track how a student engages in the day-to-day schedule of groups and basic daily living. The findings of this study indicated that the check-sheet created additional stress and anxiety in the lives of participants and served to make them feel like children. The feedback from participants raises the importance of examining how the system is being implemented and whether a different system is warranted for young adults in treatment settings due to the unique developmental tasks of emerging adults of moving from dependence to independence (Levy-Warren, 1999).

Dating policy. This is another area where there was a higher percentage (41%) within the hindering incidents than the supportive (17%). The primary concern was the inconsistency of management and consequences when the policy was broken. Within substance abuse treatment programs and 12-step programs, the literature encourages individuals in recovery to not date for a minimum of one year (Smith & Wilson, 1939/2013). Several of the primary reasons cited were that romantic relationships can turn attention outwards and away from the recovery and healing process, and that honest and full participation in groups and therapy can be impacted when energy is being channeled into a new relationship. From a developmental perspective one of the tasks of an emerging adult is the discovery and development of connection with others; from a treatment perspective there is an assumption that romantic relationships are a detriment to growth. Due to the lack of literature on transition programs, there is scant information on how this model might best approach the topic of romantic relationships and the misalignment felt by participants.

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Exercise. This is an area where only supporting incidents were reported (29%). A large body of research supports the use of exercise as a treatment for depression and anxiety across a wide range of ages and with special populations. Evidence shows that habitual physical activity is important for both mental and physical well-being (Greer & Trivedi, 2009; Larun, Nordheim, Ekeland, Hagen, & Heian, 2006; Lawlor & Hopker, 2001; Matthews & Moran, 2011; Mead et al., 2009; Sjosten & Kivela, 2006).

Medication and medical management. This is a critical area for programs to evaluate. Youth in residential treatment often present with significant and complex emotional and behavioral disorders (Child Welfare League of America, 2005; Duppong-Hurley et al., 2009) and have often been unsuccessful in previous, less restrictive settings (Pottick et al., 2008). These youth are more likely to have prescriptions for psychotropic medications with up to 55% taking three or more different psychotropic medications (Griffith et al., 2010). Due to the complexity of diagnoses and psychotropic medication use, physicians have the difficult task of sorting through all of the intake information and determining the accuracy of the diagnosis and the effects of prescribed medications (Griffith, Epstein, & Huefner, 2013). The findings in this study suggest that interpersonal interactions and trust with prescribing and treating physicians, is also of importance and attention needs to be paid to how best to involve the participant and family in decision-making.

Another area mentioned by participants in the study was the perception of not being taken to the doctor quickly enough when requested. It can be useful for program personnel to work directly with young adults to educate them on when a doctor's visit is needed versus when it may simply be a cold or a behavioral pattern for the student.

Groups. Therapeutic, recreational and life skill groups are often a component of young adult treatment programs and it has been suggested that group experiences can be a powerful change agent with efficacy demonstrated across a range of approaches including cognitive-behavioral therapy and social skills training (Caruso et al., 2013). However, there is a paucity of research that focuses on the participants' experiences of group sessions. This study showed that it is important for young adults to have ownership and collaboration in choosing groups. It is important that facilitators of groups have received proper training on group facilitation and come prepared with a clear agenda and goal. The skill and ability with which a group is facilitated, and a safe, non-judgmental space, foster the participant's ability to share emotions and engage in self-disclosure that contributes to the quality of relational culture: this is fundamental in promoting change (Dierick & Lietaer, 2008). Leszcz, Yalom, and Norden (1985), suggest that group experiences contribute to greater interpersonal learning and self-understanding and support participants' capacity to understand rules and codes of relationships and unconscious motivations that may underlie a certain behavior. This relates to attachment theory; groups can support a participant to examine insecure or maladaptive coping styles.

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Groups that include an experiential component where a skill is taught, and where there is opportunity to practice and reflect, are often well received by participants. The added component of experiential education has great potential to connect intellect and emotions to everyday tasks and life challenges and this is often done within the context of relational human experience (Sutherland & Jelinek, 2015). Experiential education supports a transformation of experience into new knowing through perception, cognition, and behavior in an adaptive process (Kolb, 1984). This transformation or new level of understanding occurs at the intersection of engaged participation and making connections between that event and one's self. Connections arise through sensemaking, and giving meaning to an experience (Weick, 1995; Weick, Sutcliffe, & Obstfeld, 2008).

The Café (A Leap of Taste). The findings in this area indicated that these young adults benefited from additional support around job skills. Participants have often not held a job or have perhaps been fired from a job. Anxiety and depression often negatively impact the work experience and yet a positive job experience can result in increased confidence, emotional resilience, and follow through on commitments.

Life skills. One of the primary objectives within young adult transition programs is to increase the ability of participants to manage life skills or independent living skills. The more a participant learns and integrates a range of life skills the more likely they are to have successful outcomes as they step into independence. Life skills cover a wide range of areas including: household management, budgeting skills, organizational skills, health and safety, transportation, recreation, hygiene, and social skills. Researchers have recently proposed that parental over-involvement in their children's basic self-care, and frequently intervening and making decisions for them plays a role in the level of anxiety in young adulthood (Cline & Fay, 1990; LeMoyne & Buchanan, 2011; Padilla-Walker & Nelson, 2012). A transition program can encourage participants to be independent through skill building and encourage them to problem solve and make independent decisions. Often, life skills are interwoven throughout the structure of a program and young adult programs would benefit further by systematically evaluating each participant to see which skills warrants further support and education. It is not uncommon for participants to have great intellect ability, yet not to have developed fundamental life skills in order to care for themselves on a day-to-day basis (Croft, Boyer, & Hett, 2009)

Implications for Practice

The findings that emerged through interviews showed the importance of interpersonal interactions, culture and community, experiential education and individualized program components. It is the entirety of the treatment container with incremental steps taken towards autonomy within a relational cultural model that creates real and meaningful change and it is rarely one incident, interaction, or intervention that is the catalyst for lasting change. These opportunities need to be incorporated into programmatic design both for the participant and the organization. Providing conversational space with neutral parties in the months

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after development of programs or the design of groups, would enhance and expand learning. These results highlight the need for more reflexive work to be built into the development of programs. To make the most of the growth opportunities, participants need space, time, and processes for reflexive work during and after learning interventions.

Growth and change requires accepting risk, failure, being vulnerable, as well as trusting oneself, and trusting others. This further substantiates calls in recent research to attend more to issues around building psychological safety and to the importance of the agency of facilitators (Beyes & Michels, 2011; Petriglieri & Petriglieri, 2010; Sutherland & Ladkin, 2013). The study points to the need for deliberate and specific training for mentors, therapists and leadership in facilitating experiential education and the culture of community. This allows for full capitalization on the opportunity for meaningful learning and change and on managing risk and potential harm (Tucker & Norton, 2013).

Furthermore, the study points to the need for increased supervision of mentors in order to support self-awareness on how they engage in interpersonal interactions with participants, which has potential to directly impact participant outcomes in a hindering or supportive manner. This study further emphasized the role that social support plays within a therapeutic community. Building trust-based and authentic relationships both within the program and without is critical to the development of a strong foundation of self and one who can confidently engage in the world. The skills need to be practiced beyond the treatment environment so the young adult has the confidence that they can be replicated in their everyday life. This means that participants benefit from programs with flexibility in individualizing and normalizing what is inherently a messy life as one engages in adulting. The assumption would be that as programs support incremental autonomy for the young adult to experience trial and error within the structure and support scaffolded throughout the program, their process resistance decreases and everyday engagement in life becomes normalized and less anxiety-provoking. The young adult benefits from support within a secure and relational environment to develop a reflexive practice where they examine, learn from, and take ownership of their choices

As seen in Figure 5.1, the transition model of change, and in congruence with much of what is known about milieu treatment, young adult transition models should be holistic and inclusive of a variety of treatment and life skill options, including specific developmental and individualized tasks for this particular age group. In particular, the development of a hands-on vocational program has proven to be a critical program component for young adults in developing confidence and their belief that they are capable of a successful work experience.

Deep and lasting change is complex, time-consuming, and requires intention and interconnectedness across many areas of an individual's life. There is not one particular treatment method or model that will solve all challenges; rather, it is the collective experience of shared community and experience that develops skills and confidence for an individual to engage in the difficult work of change

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and transition and to take responsibility for their life as an adult. The work done within a therapeutic environment has to transcend transactional interactions where employees and participants alike are motivated by a “carrot” to meet expectations and “beaten with a stick” for failing in what was supposed to be done and shift into the realm of transformational leadership and interactions which supports an internal process of change for everyone associated (Bass & Bass, 2008). Understanding and fostering transformational leadership within an organization creates a meaningful and engaging change experience for participants and employees alike and the theory encapsulates much of what participants discussed in this study.

Transformational leadership is defined as an approach that supports change in individuals and social systems (Burns, 1978), which in turn supports the emerging adult to meet developmental milestones within a supportive and structured environment, with flexibility and empowerment. In its ideal form, transformational leadership creates valuable and positive change in the participants with the end goal of becoming leaders themselves. Enacted in its authentic form, transformational leadership enhances the motivation, morale and performance of participants through a variety of mechanisms, which include: connecting the participants’ sense of identity and self to the task and the collective identity of the organization, or to their personal life plan; being a role model for participants that inspires them; challenging participants to take greater ownership for their work; and understanding the strengths and weaknesses of each individual, so the leader can align them with tasks and a direction that optimize their performance and success (Bass, 1985, Bass & Bass, 2008; Burns, 1978).

Conclusions

This study confirms, through the voices of participants, the need for individualized programming and transformational mentoring and leadership within the entire organizational model. This study supports the importance of programming built on a model of relational cultural practice, which includes sensitivity to and honoring of the individual with collaboration and mutuality. This study also supports continued programmatic evaluation and the importance of including the perspective of the participants and all stakeholders and supports continued research towards evidence-based practice within the young adult transition model.

Limitations of the Study

This study was undertaken in an area with nascent knowledge, but with little documented research on the specific area of what supports or hinders young adults in treatment; however, there was a plethora of literature that informed the study. It was an exploratory, instrumental case study; qualitative research methods, much like any research method, have some limitations. Using Lincoln and Guba’s (1985) ideas on achieving trustworthiness, the methodology was designed to reduce limitations by establishing the four criteria of transferability, credibility, confirmability, and dependability. The study was modest in both scale

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and scope, which impacts the generalizability of the results to other young adult programs. However, through the nine credibility checks there is increased rigor that enhances the validity of the study and explores a real-life problem relevant to clinical practice (Blustein, 2001; Butterfield et al., 2005; Subich, 2001; Walsh, 2001). In addition to the methodological limitation of a case study, it is important to understand the limitations of the actual study sample. The study sample comes from a private-pay organization and as such may not be transferable to government-funded organizations. Behrens and Satterfield (2006) suggest that private-pay programs are different enough from government-funded programs that separate research is needed to explore effectiveness. Last, the sample group of the program alumni was voluntary, which potentially introduces bias.

Suggested Future Research

Future research could incorporate the voices of the families and employees of an organization and therefore assess congruence with alumni stories. Studies could be designed to understand the experience from the perspective of the whole organization where all stakeholders are incorporated, including families and employees.

A study using a research design that sampled across several young adult transition programs would address the potential challenge of transferability of a single case study. This could begin the process of identifying on a larger scale and with a wider range of participants, what supports or hinders young adults in transition and treatment. Subsequently a quantitative survey could be developed based on the critical themes found within young adult organizations. Future researchers may also want to consider implementing a similar study of government-funded programs to see if the themes found in this study extend beyond socio-economics, gender, ethnicity, or race, and whether this type of treatment may be helpful to a wider range of participants.

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