Cultural Islands: The Subjective Experience of Treatment and Maltreatment within Insular Programs

Mark Chatfield
University of Florida

This is a brief, selective summary of a thesis research project titled "Adult Perspectives on Totalistic Teen Treatment: Experiences and Impact." This project was approved by the University of Florida Institutional Review Board Office (UF–IRB201701655). The summary presented here reports on findings most closely related to the topics of insularity, the potential for harm, and underrepresentation. Since the most "positive" accounts may not fall within the intersection of these topics, some participants who reported being helped or even saved by their program experience are not represented in this essay. To balance this report, the most "negative" findings have also been omitted, despite their relevance to this essay's topics. This decision is informed by a desire to counter some of the negativity bias inherent to the subject area.

The term "totalistic" is used here to describe an array of milieu features and methods associated with insular, autocratic treatment programs (De Leon, 2000) and total institutions (Goffman, 1961)

Subjectivity Statement: *On a few occasions during my short career as an aspiring social scientist, I have been warned that my interest in the prevention of harm may be a threat to objective scientific inquiry. As a qualitative researcher, I appreciate the need to build credibility with readers and to design research methods that build in safeguards against unchecked biases. In this study, each decision about instrument development, recruitment, data collection, analysis, and reporting of findings was weighed with the skeptical reader in mind. The validity and usefulness of qualitative research must be assessed by each individual reader. In this brief essay, I have not provided a full review of the many choices that shaped this project. But I have done my best to take each step forward with vigilance, hoping that rigorous consistency would add depth and value to any findings.*

that utilize a closed group dynamics approach (Grant & Grant, 1959) to affect global personal change. The term also implies the assumption that the totality of simultaneous, clustered conditions (Leach, 2016) are a primary "active ingredient" within intensive treatment milieus. The concept of totalistic treatment was operationalized by identifying seven key program characteristics: (1) controlled communication, (2) strict rules and punishments, (3) routine peer policing, (4) frequent group confession and/or confrontation sessions, (5) a philosophy mandating total personal change, (6) progression through required levels of treatment and (7) at least one level with all aspects of life under the control of a central authority.

The insular nature of totalistic treatment environments presents a unique paradox. The therapeutic potential of the milieu may be enhanced by eliminating outside influences but at the same time, the risk of harm may also increase proportionally as control and power are concentrated within the milieu. This essay proposes a need for qualitative research that explores and analyzes firsthand accounts of adults who have lived within such programs.

Identifying the Population and Locating the Problem

An unknown number of youth have been reeducated, rehabilitated, and reformed within a wide variety of insular treatment milieus within the United States. They lived for weeks, months, or years in boot camps, residential treatment facilities, wilderness programs, juvenile justice programs, psychiatric hospitals, group homes, faith-based treatment centers, therapeutic communities, and boarding schools. They were admitted by concerned parents, placed by foster care professionals, or adjudicated by the state to be treated for a wide variety of issues such as substance abuse, learning disabilities, developmental disorders, sexual deviance, or general delinquency and defiance. A large but unknown number have received such treatment, but very little is known about the way *maltreatment* has been experienced in these settings and perhaps

even less is known about the way totalistic programs affect adult development.

The current size of this population is also unknown. Grouphome population estimates range from 56,000 (Izzo, et al., 2016) to 212,000 (Thoburn & Ainsworth, 2015). An additional 50,000 reside within juvenile justice facilities on any given day (OJJP, 2014) and as recently as 2008, more than 200,000 youths resided in federally-funded residential treatment programs (GAO–08–346, 2008). It is difficult to estimate the number of youth residing in privately operated *state-licensed* programs, but even less is known about youth residing in *unlicensed* programs that function without oversight. In 2006, the American Bar Association estimated that 10,000 to 15,000 youths were placed in unlicensed programs each year (Behar et al., 2007).

Although there is growing consensus for the promotion of evidence-based practices (Boel-Studt & Tobia, 2016) only a handful of proven methods are currently implemented within residential care settings for youth (James et al., 2015). Within the juvenile justice system, some estimates find that only 5% to 11% of court-ordered youth receive evidence-based care (Walker, Bumbarger, & Phillippi, 2015). "Conversion therapy" and other dangerous types of behavior modification are perfectly legal in most states despite their known potential for harm (Byne, 2015; SAMHSA, 2015; Woodhouse, 2002). The number of highly totalistic treatment settings currently providing care for youth in the United States is unknown.

When methods of forceful change rely on insularity as a source of power, they may be described as "cruel and dangerous uses of thought reform techniques" (Cases of Neglect, 2007, p. 76). When these methods are experienced as repetitive traumas within inescapable settings, youth may be at risk for unique types of psychological harm (Ebert & Dyck, 2004; Herman, 1992). Some might argue that youth experiences of institutional abuse within treatment settings are scarce in the literature because this type of harm is rare. However, it is more likely that the lack of research is due to the insular nature of totalistic milieus.

Linking Insularity and Underrepresentation

The therapeutic rationale for insularity in teen treatment programs is perhaps best explained by Kurt Lewin's theory of group dynamics (Lewin, 1947; Schein, Schneier, & Barker, 1961; Schein, 1962). In this model, constant group pressure within an insulated environment is assumed to initiate a therapeutic personal change process within the individual. Although practitioners may label their methods and this process by any number of names, one of the most widely applied models based on the group dynamics approach is described by George De Leon's theory of therapeutic community (De Leon, 1995; 2000).

In this approach, problematic behaviors indicate a disorder of the whole person, requiring total transformation within an engineered social milieu capable of undermining any support for the individual's unhealthy or unwanted personal characteristics (De Leon, 1995; 2000). This requires an isolated social system that can initiate the change process by cutting ties with the outside world. By controlling the flow of information, available means of human connection, and all forms of communication, "positive" pressures can be applied more effectively. The program structure is meant to create an inescapable pressure to respond, while allowing only a narrow set of response options. In these insular treatment settings, individuals are changed by their own ability to adapt to, or survive, the demands of the milieu (Schein, 1962).

Outside influences are typically viewed as a threat because of their potential to weaken the group's power to reform an individual's personality and value structure (De Leon, 2000). Because this power is applied through group dynamics, and because newly introduced values and demands are likely to conflict with old social supports and personality structures, it is "necessary to separate the group from the larger setting" (Lewin, 1947, p. 36–37). Such isolation is crucial to this type of change process: "the effectiveness of camps or workshops in changing ideology or conduct depends in part on the possibility of creating such 'cultural islands'" (p. 37).

Underrepresentation, Awareness, and Detection

In 2008, the United States Government Accountability Office (GAO) documented numerous confirmed and reported cases of abuse and deaths within private-pay programs (GAO–08–146T, 2008; GAO–08–346, 2008; GAO–08–713T, 2008). Although the most extreme forms of abuse may be dismissed as overdramatizations (Boel-Studt & Tobia, 2016) or explained as a problem that existed primarily in the past (Reamer & Siegel, 2008), federal investigations and congressional hearings revealed widespread systematic abuse, industry-wide deceptive marketing practices, state-level administrative failures, and a need for uniform safety standards and effective oversight. Federal legislation, meant to prevent institutional child abuse by addressing these macro level factors, was proposed as early as the 1980s (Interstate Consortium, 1980) and apparently, has been introduced annually since 2008 but has yet to be enacted.

There are no federal safety standards or federal data-reporting requirements for privately funded programs, and state-level reporting requirements vary (GAO–08–346, 2008, i; H.R. 3024, 2017; Overcamp-Martini & Nutton, 2009). In addition to regulatory concerns, a persistent lack of definitional agreement on institutional forms of maltreatment creates barriers to research and prevention (Burns, Hyde, & Killet, 2013; Daly, 2014; Rabb & Rindfleisch, 1985, Penhale, 1999). Complicating this lack of regulatory and definitional boundaries, the domains of policy, practice, and research are primarily informed by the perspectives of adults who trust care providers to define for themselves what constitutes "treatment" and "maltreatment." Those on the receiving end may not be asked or may find it difficult to describe any overwhelming reactions or negative side-effects.

Whatever the program's purpose, philosophy, or licensing status, a wide range of program types have been considered together as "the black box" of residential treatment (Harder & Knorth, 2015; Palareti & Berti, 2009). They are characterized by their closed doors and our inability

to make meaningful generalizations about what goes on behind them. These settings can be characterized by how insular, restrictive, and intrusive they are, but rather than thinking in dichotomous terms, it may be more important to conceptualize their features on a continuum of "*how* totalistic" they may be. Total institutions for adults have been characterized by a range of controls on personal autonomy and communication with the outside world (Goffman, 1961). For youth, the ability to communicate freely with family and friends in the outside world is often limited or impossible, and censored or controlled forms of communication are often contingent upon compliance with harsh demands. In these environments some may be unable or afraid to report abuse because of the threat of further restrictions and punishment (Behar et al., 2007).

The Need for Qualitative Research

Only a handful of qualitative studies examine youth perspectives on highly restrictive environments (Chama & Ramirez, 2014; MacLeod, 1999; Polvere, 2011; Rauktis, 2016; Rauktis, Fusco, Cahalane, Bennet, & Reinhart, 2011). In these studies, a range of totalistic program features are described with varying degrees of detail. Additional examples of firsthand accounts within highly restrictive environments describe adult treatment settings (Frankel, 1989; Gowan & Whetstone, 2012; Hood, 2011; Skoll, 1992). There is a lack of research examining the firsthand accounts of adults who, as adolescents, spent weeks, months, or years of their lives inside a highly totalistic treatment program. This type of research might help to explain some of the features that characterize potentially harmful program types (Farmer, et al., 2017). Additionally, the discourse on evidence-based practices would benefit from a wider range of evidence that considers the impact of totalistic program methods.

Current ethics of care assume that treatment providers will rely on the least restrictive and least intrusive methods (Simonsen, Sugai, Freeman, Kern, & Hampton, 2014; Weithorn, 2005). Although this

standard is widely known, its meaning is fuzzy and questionable because current perspectives and measures of restrictiveness and intrusiveness are typically framed by adults rather than their youth targets (Polvere, 2011; Rauktis, et al., 2011). Qualitative research may help shine a light behind closed doors and illuminate the subjective experiences of this underrepresented and often stigmatized population.

To explore the subjective experiences reported by adults who lived within totalistic teen treatment environments, this study was designed to answer three research questions: How are totalistic teen treatment methods experienced? How do participants describe the immediate effects of the program? And how do they describe the long-term impact of the program?

Methods

In the first stage of this project, 223 individual responses to an online questionnaire were collected for quantitative analysis and to identify potential interview participants. Seventy-four program facilities were represented in the original sample of 223 participants, and 71 of these programs were rated as highly totalistic. Sixty-six percent of respondents identified as female and 89% as White. The second stage of the study began with the creation of a sampling frame of respondents who rated their program as highly totalistic. Seven program characteristics were measured on a 5-point scale and participants with a mean index score below 4.00 were screened-out to ensure that qualitative data would be collected only from those who had experienced a "highly totalistic" teen treatment program. A total of 190 adults with a mean score of 4.00 to 5.00 were identified as the interview sampling frame. Electronically recorded qualitative data were collected during one-hour phone interviews with 30 participants selected from the frame. Each interview followed the same basic protocol, but participants were encouraged to speak to what was most important to them. All interviews were fully transcribed and coded line by line for categorical, comparative, and thematic analyses.

Findings

Participants described four types of programs: therapeutic boarding school; residential treatment; wilderness/outdoor; and intensive outpatient. The majority described censored written communications to and from parents and brief, infrequent, closely monitored phone calls. Communication with parents was frequently described as a privilege earned through obedience that could be taken away for rule violations. All participants reported that the *content* of communications was also closely monitored and for many, communication with parents could be restricted if they were caught complaining about the program. Perhaps more profoundly, some mentioned that complaints about the program might be taken as an indication that one's personal mental health was failing, and staff could present this to parents as evidence that their children were "not ready" to communicate with the outside world and needed to focus more intensely on themselves.

> I remember being like, "why am I in a place where I can't be in contact with the outside world? Why do I not get to be allowed to look out the windows? Why am I not allowed to know the news? Why can't I, like, contact any of my friends or family?" Just feeling really trapped and not really having any way to express that because, like, you couldn't express that to the staff without consequence, you would be punished for it and get consequences, negative talk of the program was met with a consequence.

The content and amount of communication between residents was also strictly controlled and enforced by threat of punishment, loss of privileges, and additional time spent on lower levels of the program. Books, magazines, movies, music, television, and Internet access were restricted, redacted or completely forbidden. Some described formal program structures that forbade "fluff talk"—superficial topics of conversation not directly pertaining to one's personal problems.

A range of different types of isolation punishments were described by several participants, some involving multiple days spent in tiny rooms.

More than one participant described an isolation practice where youth who had "maxed out" their time in formal isolation could be forced to sit in isolation at their desks or in the corner of a room, made to stare at a wall all day long for months on end.

> The longest I experienced it was two weeks, but someone who had attended 10 years after me told me they were there for a month, which is mind-boggling. I don't know how you could do that without causing psychological damage, it's just an isolation chamber with people constantly being around you.

More common forms of isolation punishments were called "blackouts," "bans," or being put on "ghost challenge." The name of the practice differed across multiple programs but in all such cases, youth were forbidden to speak or interact with others while moving through the day's schedule.

> We weren't able to look out the window, free communication with other students wasn't really a thing, it was very, very strict, so just a lot of forced silence. And then a lot of, I think they would call them special processes or special challenges that other girls would be placed on, as far as, they would be on a ghost challenge, so no one was allowed to look at them or talk to them for a certain period of time.

These modified seclusion practices could be imposed for many weeks or months, and the impact of such practices extended to those witnessing them. Participants described emotional distress and anxiety because they were unable to intervene, or were punished for attempting to intervene, while other youth were subjected to severe punishments, injustices, or medical neglect. They described an autocratic authority structure where any attempt to defend a peer against staff decisions would result in severe consequences.

They describe an environment totally insulated against outside influences but also designed to prevent any sense of privacy or personal autonomy. These deprivations were typically experienced with a

sense of powerlessness and an inability to find relief from the relentless pressure of "being poked at" and confronted. Group humiliation rituals were frequently reported to occur in the context of therapy and many described the program's effect as a process of being torn down and built back up.

> Every single aspect of who you are and what has ever happened to you and what you know is shattered and taken away and you're told you're wrong and you don't trust your memory and you have to completely rebuild your personality, your interests, your favorite color, like all this stuff, before you're allowed to leave.

For many, the process of readjusting to life outside the program was also traumatic. A large number reported feeling unprepared for life in the "real world." Many were unable to mend friendships that had been disrupted by their sudden absence and inability to communicate. A theme of shattered trust, especially for those who experienced emotional trauma, was exacerbated by barriers to free communication. Many described a long-term struggle to explain their experiences to parents and frustration over not being believed when they described them. Others mentioned current uncertainty about how much their parents knew or didn't know about daily life in the program. For some, the process of coming to terms with the experience of trauma was impaired by self-blame and internalized program philosophies: "basically that we're responsible for everything that happens to us and you know if something negative happens then there was something you did that you need to be accountable for." Others mentioned feeling afraid to complain about the program after reentry because their parents were instructed to consider placing them in treatment again if they began speaking negatively of the program.

When participants were asked about the way their perspective had changed over the years, many said they spoke more glowingly about their experiences in the first years after graduation or release. Progress through, and graduation from, the program was contingent on having a positive opinion about the experience. Several described a long process

of denial, disillusionment, and acceptance, taking many years for some of them to become comfortable "swallowing" not just the way they were treated but the way they treated others when participating in group confrontations.

> The best way to avoid a heavy confrontation was to confront other people about things that you saw them do. When I think about some of the things that I personally confronted people about in group, a lot of them, it's probably the meanest I've ever been to anybody.

Most interviewees wanted to participate in this study to help raise awareness and prevent harm. They want parents and guardians to know what goes on in such programs and "that these places exist."

Relevance to Practice

Participants in this study reveal much about the way orchestrated group dynamics can become "self-sealing systems," as described by Janja Lalich in *Bounded Choice: True Believers and Charismatic Cults* (2004). In cultic dynamics, Lalich describes how systems of domination and affiliation within insular groups can facilitate internalization of organizational values. She describes how this process strengthens loyalty to the group, intensifies emotional bonds between members, and may lead to personal closure that insulates participants against outside sources of information and creates distance from one's own pre-group identities.

In the research summarized here, almost all participants reported that some of their strongest memories stem from close bonds they formed with peers in the program. Many noted this as a paradox and a few used the term "double-edged sword" to describe the effects of intense social dynamics within a closed environment. The majority of those who attributed positive effects and outcomes to their program experiences emphasized that such benefits were in addition to a range of negative effects and long-term harm. This complex mix was described by many as a range of paradoxical extremes that includes connection

and growth as well as "brainwashing" and memories of "brutal" conditions. During several interviews, participants interrupted themselves to apologize for "sounding so negative," or to explain why it was so complicated. Several noted that for many years, the struggle to explain their experiences had been a continual cause of stress and alienation.

Practitioners may describe residential treatment according to the way they imagine their methods to work. However, there is a difference between the way methods are conceptualized by adults and the way they are experienced by youth. This unresolved dichotomy contributes to the potential for psychological harm in residential treatment settings (Zimmerman, 2004). The potential for such iatrogenic effects can be obscured by the recurrent use of words and phrases that enhance institutional power while invalidating the subjective experience of harm (Thomas, 1982). When professionals dismiss charges of institutional maltreatment as a youth's attempt to manipulate adults, reports of abuse may be reduced to a symptom of pathology and assumed to indicate need for even more intensive treatment.

While it is important to predict the effectiveness and beneficial impacts of any intervention, it is equally important to be able to identify and prevent negative side-effects and harm. To predict unwanted outcomes, such outcomes must first be understood from the standpoint of the individuals who have direct knowledge about them. Only then can the discourse on persuasion, thought reform, treatment and maltreatment move beyond polemic reactions (Zablocki, 1997) and simplistic dominant narratives (Polvere, 2011) that may ignore unintended and harmful side-effects of insular programming within totalistic settings. This type of prevention science would require theoretical knowledge and the capacity for prediction through "dark logic" models (Bonell, Jamal, Melendez-Torres & Cummins, 2014) that would approach institutional abuse as a "wicked problem" (Burns, Hyde, & Killet, 2013). These models would need to be developed and informed by a wide range of data, including rigorous, systematic analyses of firsthand accounts and subjective experiences (Smith, 2010).

Conclusion

This summary describes one of few studies to examine totalistic treatment as a characteristic set of restrictive and intrusive practices applied simultaneously within insular environments. The 30 participants interviewed in this study lived for an average of 20 months within a highly totalistic teen treatment program. They explained their subjective experiences of life within one facility location and a total of 25 different programs were described at length. These treatment settings can be characterized by the same set of interwoven totalistic features that should be considered together as simultaneous factors characterizing the milieu structure and program type.

Several participants interviewed in this study were released from such a milieu only within the last few years, but their collective experiences span across four decades, with intake dates from 1982 to 2016. The findings indicate that some youth living within highly insular environments have experienced aspects of totalistic teen treatment as institutional abuse. An unknown number of Americans have lived for months and years within the high-pressure vacuum of a "cultural island," and when they are asked to shine a light behind closed doors, they describe a range of institutional practices that warrant further investigation, research, and prevention.

References

Behar, L., Friedman, R., Pinto, A., Katz-Leavy, J., & Jones, H. W. G. (2007). Protecting youth placed in unlicensed, unregulated residential "treatment" facilities. *Family Court Review, 45*(3), 399-413. doi:10.1111/j.1744-1617.2007.00155.x

Boel-Studt, S. M., & Tobia, L. (2016). A review of trends, research, and recommendations for strengthening the evidence-base and quality of residential group care. *Residential Treatment for Children & Youth, 33*(1), 13. doi:10.1080/08865 71X.2016.1175995

Bonell, C., Jamal, F., Melendez-Torres, G. J., & Cummins, S. (2015). 'Dark logic': Theorising the harmful consequences of public health interventions. *Journal of Epidemiology and Community Health, 69*(1), 95–98. doi:10.1136/jech-2014-204671

Burns, D., Hyde, P., & Killett, A. (2013). Wicked problems or wicked people? reconceptualising institutional abuse. *Sociology of Health & Illness, 35*(4), 514–528. doi:10.1111/j.1467-9566.2012.01511.x

Byne, W. (2016). Regulations restrict practice of conversion therapy. *LGBT Health, 3*(2), 97–99. doi:10.1089/lgbt.2016.0015

Cases of child neglect and abuse at private residential treatment facilities: Hearing before the committee on education and labor: House of Representatives, 110th Cong. (2007). Retrieved from: https://www.gpo.gov/fdsys/pkg/CHRG-110hhrg38055/pdf/CHRG-110hhrg38055.pdf

Chama, S., & Ramirez, O. (2014). Young people's perceptions of a group home's efficacy: A retrospective study. *Residential Treatment for Children & Youth, 31*(2), 120-134. doi:10.1080/0886571X.2014.918442

Daly, K. (2014). Conceptualising responses to institutional abuse of children. *Current Issues in Criminal Justice, 26*(1), 5–29.

De Leon, G. (1995). Therapeutic communities for addictions: A theoretical framework. *International Journal of Addictions, 30*(12), 1603–1645. doi:10.3109/10826089509104418

De Leon, G. (2000). *Therapeutic community: Theory, model, and method*. New York: Springer Publishing Company.

Ebert, A., & Dyck, M. J. (2004). The experience of mental death: The core feature of complex posttraumatic stress disorder. *Clinical Psychology Review, 24*(6), 617–635. doi:10.1016/j.cpr.2004.06.002

Farmer, E. M. Z., Murray, M. L., Ballentine, K., Rauktis, M. E., & Burns, B. J. (2017). Would we know it if we saw it? assessing quality of care in group homes for youth. *Journal of Emotional and Behavioral Disorders, 25*(1), 28–36. doi:10.1177/1063426616687363

Frankel, B. (1989). *Transforming identities: Context, power and ideology in a therapeutic community*. New York: Peter Lang.

GAO-08-346, House of Representatives, Report. (2008). Retrieved from: https://www.gao.gov/new.items/d08346.pdf

GAO-08-146T: Residential treatment programs: Concerns regarding abuse and deaths in certain programs for troubled youth: United states government accountability office testimony before the committee on labor and education: House of Representatives, (2008). Retrieved from: https://www.gao.gov/new.items/d08146t.pdf

GAO-08-713T: Residential programs: Selected cases of death, abuse, and deceptive marketing: United states government accountability office testimony before the committee on education and labor. House of Representatives, (2008). Retrieved from: https://www.gao.gov/new.items/d08713t.pdf

Goffman, E. (1961). *Asylums*. New York, NY: Anchor Books.

Gowan, T., & Whetstone, S. (2012). Making the criminal addict: Subjectivity and social control in a strong-arm rehab. *Punishment & Society, 14*(1), 69–93. 10.1177/1462474511424684

Grant, J. D., & Grant, M. Q. (1959). A group dynamics approach to the treatment of nonconformists in the navy. *The Annals of the American Academy of Political and Social Science, 322*(1), 126–135. doi:10.1177/000271625932200116

Harder, A. T., & Knorth, E. J. (2015). Uncovering what is inside the 'black box' of effective therapeutic residential youth care. In Whittaker, J. K., del Valle, J. F. & Holmes, L. (Ed.), *Therapeutic residential care for children and youth: Developing evidence-based international practice* (pp. 217–230). London & Philadelphia: Jessica Kingsley Publishers.

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress, 5*(3), 377–391. doi:10.1002/jts.2490050305

Hood, D. E. (1992). *Addiction treatment: Comparing religion and science*. New Brunswick: Transaction Publishers.

H. R. 3024, Stop child abuse in residential programs for teens act of 2017. 115th cong. (2017). Retrieved from: https://www.congress.gov/115/bills/hr3024/BILLS-115hr3024ih.pdf

Interstate Consortium on Residential Child Care. (1980). *Residential child care guidebook*. Trenton, NJ: The Interstate Consortium, Department of Human Services.

Izzo, C. V., Smith, E. G., Holden, M. J., Norton, C. I., Nunno, M. A., & Sellers, D. E. (2016). Intervening at the setting level to prevent behavioral incidents in residential child care: Efficacy of the CARE program model. *Prevention Science, 17*(5), 554–564. doi:10.1007/s11121-016-0649-0

James, S., Thompson, R., Sternberg, N., Schnur, E., Ross, J., Butler, L., . . . Muirhead, J. (2015). Attitudes, perceptions, and utilization of evidence-based practices in residential care. *Residential Treatment for Children & Youth, 32*(2), 144–166. doi:10.1080/08865 71X.2015.1046275

Lalich., J. (2004). *Bounded choice: True believers and charasmatic cults*. Los Angeles: University of California Press.

Leach, J. (2016). Psychological factors in exceptional, extreme and torturous environments. *Extreme Physiology & Medicine, 5*(1), 7. doi:10.1186/s13728-016-0048-y

Lewin, K. (1947). Frontiers in group dynamics: Concept, method and reality in social science; social equilibria and social change. *Human Relations, 1*(1), 5–41.

MacLeod, M. (1999). The abuse of children in institutional settings: Children's perspectives. In N. Stanley, J. Manthorpe & B. Penhale (Eds.), *Institutional abuse: Perspectives across the life course* (pp. 44–65). New York: Routledge.

Office of Juvenile Justice Programs (OJJP). (2014). *Coming into focus: The future of juvenile justice reform.* Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention. Retrieved from: https://www.ojjdp.gov/pubs/248957.pdf

Overcamp-Martini, M., & Nutton, J. (2009). CAPTA and the residential placement: A survey of state policy and practice. *Child & Youth Care Forum, 38*(2), 55–68. 10.1007/s10566-009-9067-9

Penhale, B. (1999). Introduction. In Stanley, N., Manthorpe, J. & Penhale, B. (Eds.), *Institutional abuse: Perspectives across the life course* (pp. 1–15). London & New York: Routledge.

Polvere, L. (2011). Youth perspectives on restrictive mental health placement: Unearthing a counter narrative. *Journal of Adolescent Research, 26*(3), 318–343. doi:10.1177/0743558410391257

Palareti, L., & Berti, C. (2009). Different ecological perspectives for evaluating residential care outcomes: Which window for the black box? *Children and Youth Services Review, 31*(10), 1080-1085. doi:10.1016/j.childyouth.2009.07.011

Rabb, J., & Rindfleisch, N. (1985). A study to define and assess severity of institutional abuse/neglect. *Child Abuse & Neglect, 9*(2), 285–294. 10.1016/0145-2134(85)90021-3

Rauktis, M. E., Fusco, R. A., Cahalane, H., Bennett, I. K., & Reinhart, S. M. (2011). "Try to make it seem like we're regular kids": Youth perceptions of restrictiveness in out-of-home care. *Children and Youth Services Review, 33*(7), 1224–1233. doi:10.1016/j.childyouth.2011.02.012

Rauktis, M. (2016). "When you first get there, you wear red": Youth perceptions of point and level systems in group home care. *Child and Adolescent Social Work Journal, 33*(1), 91–102. doi:10.1007/s10560-015-0406-4

Reamer, F. G., & Siegel, D. H. (2008). *Teens in crisis: How the industry serving struggling teens helps and hurts our kids*. New York: Columbia University Press.

Schein, E. H., Barker, C. H., & Schneier, I. (1961). *Coercive persuasion: A socio-psychological analysis of the "brainwashing" of american civilian prisoners by the chinese communists*. New York: Norton.

Schein, E. (1962). Man against man: Brainwashing. *Corrective Psychiatry and Journal of Social Therapy, 8*(1–4), 90–97.

Simonsen, B., Sugai, G. M., Freeman, J., Kern, L., & Hampton, J. (2014). Ethical and professional guidelines for use of crisis procedures. *Education and Treatment of Children, 37*(2), 307–322. 10.1353/etc.2014.0019

Skoll, G. R. (1992). *Walk the walk and talk the talk: An ethnography of a drug abuse treatment facility*. Philadelphia: Temple University Press.

Smith, M. (2010). Victim narratives of historical abuse in residential child care. *Qualitative Social Work, 9*(3), 303–320. doi:10.1177/1473325010367816

Substance abuse and mental health services administration (SAMHSA). (2016). Ending conversion therapy: Supporting and affirming LGBTQ youth. Retrieved from: https://store.samhsa.gov/shin/content/SMA15-4928/SMA15-4928.pdf

Thoburn, J., & Ainsworth, F. (2015). Making sense of differential cross-national placement rates for therapeutic residential care. In J. K. Whittaker, J. F. del Valle & L. Holmes (Eds.), *Therapeutic residential care for children and youth: Developing evidence-based international practice* (pp. 37–46). Philadelphia: Jessica Kingsley Publishers.

Thomas, G. (1982). The responsibility of residential placements for children's rights to development. *Child and Youth Services, 4*(1–2), 23–45. doi:10.1300/J024v04n01_05

Walker, S. C., Bumbarger, B. K., & Phillippi, S. W. (2015). Achieving successful evidence-based practice implementation in juvenile justice: The importance of diagnostic and evaluative capacity. *Evaluation and Program Planning, 52*, 189–197. doi:10.1016/j.evalprogplan.2015.05.001

Weithorn, L. A. (2005). Envisioning second-order change in america's responses to troubled and troublesome youth. *Hofstra Law Review, 33*(4), 1305.

Woodhouse, B. B. (2002). Speaking truth to power: Challenging "the power of parents to control the education of their own". *Cornell Journal of Law and Public Policy, 11*(3), 481.

Zablocki, B. (1997). The blacklisting of a concept: The strange history of the brainwashing conjecture in the sociology of religion. *Nova Religio: The Journal of Alternative and Emergent Religions, 1*(1), 96–121. doi:10.1525/nr.1997.1.1.96

Zimmerman, D. P. (2004). Psychotherapy in residential treatment: Historical development and critical issues. *Child and Adolescent Psychiatric Clinics of North America, 13*(2), 347–361. doi:10.1016/S1056-4993(03)00122-6