Residential Treatment of Adolescents Who Do Not Return to Their Families

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This study assessed a residential psychiatric treatment system with respect to its handling of adolescents who are unable, for a variety of reasons, to live with their families after discharge. The study was conducted to assess the potential role of residential treatment facilities in providing services to this population. Records from all 186 adolescents released in 1988 from a system of 11 treatment centers were examined, and case studies of adolescents who were 1 to 12 years postdischarge were also analyzed. Results indicated that: (a) a substantial proportion of all adolescents discharged from residential settings did not return to live with their families; (b) this outcome was only moderately predictable from data available at intake; and (c) adolescents experienced postdischarge problems in areas of social interactions and managing the pragmatic tasks needed to live independently. Results are interpreted as indicating the need for a developmental approach to residential treatment that recognizes adolescents' need to learn age-appropriate social and independent living skills that are not automatically acquired in residential settings.

The inability of a family to deal with the needs of its children often results in an ongoing crisis for social welfare systems. Although permanency planning legislation is designed to foreshorten such crises by enabling quick permanent placements for youths needing them (Broeck & Barth, 1986), adolescents often defy easy placement, particularly once they have spent time in out-of-home care (Barth & Berry, 1987; Hornby & Collins, 1981). These young people will often require not only placement, but also opportunities to learn to live independently at an early age (Crystal, 1986; Zimmerman, 1982). Unfortunately, the need for placement is often
sudden, and thus leaves little time to help adolescents plan and work toward their eventual emancipation.

This study examines the potential role of a major provider of services to this population of—residential psychiatric treatment centers—in addressing this problem. Adolescents who are in residential treatment and who will not, for any of a number of reasons, be able to return to live with their families face a particularly stressful combination of problems (Itzkowitz, 1985). For example, adolescents’ provocative behaviors often make it difficult to find them placements, which in turn only increases their frustration and tendency to act out. Although not all adolescents who require out-of-home placement will pass through residential facilities, many at highest risk of psychological and behavioral difficulties will. Such centers often treat adolescents over a period of time, and thus have a rare opportunity to intervene to meet the needs of high-risk adolescents who cannot live with their families.

Unfortunately, we know very little about adolescents who both require residential psychiatric treatment and lack families with whom they can live. This condition may arise from a variety of conditions from uncontrollable, destructive adolescent behavior, to parental abandonment, to child maltreatment. What members of this group share in common, however, is that they will spend a significant portion of their adolescence outside the type of environment from which most adolescents learn basic independent living skills. Currently, even basic data indicating the prevalence of this group within a residential treatment population are lacking. Because these centers are more widely available and less costly than inpatient psychiatric hospitals, they serve large numbers of adolescents (approximately 20,000 adolescents/year) who are facing serious social, emotional, and educational adjustment difficulties, but who don’t require acute hospitalization (Tambe & Barrett, 1985). Furthermore, we know that it is often because of severe family dysfunction that many adolescents end up in residential treatment. This suggests that adolescents in residential treatment may be much more likely to lack families with whom they could successfully live than would the general population of adolescents, although few data exist in this area.

We also have little information about the specific treatment needs of this population of adolescents. One likely need—addressing the emotional issues surrounding the loss (or enduring absence) of a supportive family—is suggested by both developmental and clinical theories (Bowlby, 1980; Klein, 1976). Empirical research on adolescents in foster and group care suggests that difficulties associated with such losses are regularly experienced by adolescents who cannot live with their families (Anderson & Simonitch, 1981; Fanshel & Shinn, 1978; Festinger, 1983).

A developmental perspective suggests a second, less obvious area of need: Adolescents without families are likely to need help in learning to accomplish basic tasks of independent living. Such tasks include learning to handle money, looking for a job, finding a place to live, learning to cook, and learning where to turn in the event of an emergency. Perhaps because most adolescents learn independent living skills routinely over time, the importance of these tasks can easily be overlooked
by those charged with handling more immediate problems such as lack of shelter and severe emotional or behavioral difficulties. Yet case workers and former foster care residents have rated learning these tasks as more important than what was typically learned in counseling and psychotherapy (Crystal, 1986; Zimmerman, 1982). Failure to learn independent living skills during adolescence can also lead to later clinical problems, such as social isolation and depression, in addition to the clinical problems that first created a need for treatment (Zimmerman, 1982). The need to provide services that promote such skills in adolescents living apart from their families is increasingly being recognized (Baltimore County Department of Social Services, 1985; Crystal, 1986), although we know extremely little about how these skills are or are not obtained by adolescents who require residential psychiatric treatment.

A final problem is that we have few data that may help us to predict which adolescents entering residential psychiatric treatment will lack families to whom they can return when treatment ends. Although some factors, such as not being in the legal custody of one’s parents, are obviously going to be predictive, for many adolescents the adequacy and availability of their families are both unclear and constantly changing (Crystal, 1986). In part, of course, the adequacy of an adolescent’s family also depends on the urgency of the adolescent’s particular needs. Thus a current limit to developing services for adolescents who cannot live with their families lies in the difficulties in identifying this population of adolescents when they enter residential treatment.

This study sought to increase our knowledge of both the prevalence and the unique needs of those adolescents in residential psychiatric treatment who lack families with whom they can live. In particular, we focused upon what happens when these adolescents are discharged from residential treatment. We examined the entire population of adolescents who were discharged in 1988 from 11 residential psychiatric treatment facilities that are part of a nationwide nonprofit organization. We also conducted in-depth follow-up interviews with several adolescents without families who had been released in prior years from these centers. This study addressed three central questions:

1. How frequently are adolescents discharged from residential treatment to other than their own families?
2. How well can we predict which adolescents entering residential treatment will eventually be discharged to other than their own families?
3. What are the specific needs during and after treatment of adolescents not able to live with their families?

METHOD

Setting

The Devereux Foundation is a nationwide nonprofit organization that operates 18 residential and day treatment facilities throughout 12 states. These treatment centers serve over 2,000 children, adolescents, and adults who have a wide range
of emotional, developmental, psychiatric, and neurological disorders. The residential centers do not serve as psychiatric hospitals but as treatment facilities for disturbed young people who require intensive and ongoing treatment in a controlled environment but who do not require the more restrictive and medically oriented environment of a psychiatric hospital.

Subjects
Complete information was obtained about 169 of the 186 adolescents between the ages of 13 and 21 (M = 17.9) who comprised the entire population of adolescents released from 11 residential facilities between July 1987 and June 1988. This group represents approximately 1% of all adolescents nationwide who enter residential treatment each year. This group included 119 males and 50 females. The group was 73% white, 22% black, and 5% other. Eighty-eight percent of the adolescents had experienced some prior out-of-home placement, and 50% had not lived primarily with their parents during the year before admission. Adolescents were admitted with a wide range of problems and primary psychiatric diagnoses, particularly impulse control and conduct disorders (40%), thought disorders (15%), affective disorders (9%), autistic and pervasive developmental disorders (7%), adjustment disorders (6%), unspecified organic disorders (6%), and other problems. The median length of stay for adolescents in treatment in this sample was two years. Adolescents up to age 21 were included in the sample in part because the long median length of treatment suggests that even older adolescents would be likely to face considerable adjustments upon leaving treatment, and would be far less likely on average to live independently than more typical older adolescents.

Attempts were also made to contact a second population of 15 adolescents who had been released from Devereux between 2 and 10 years earlier, whom staff knew were not released to parents. Three of these adolescents were located and interviewed; their characteristics are described more fully in the Results section.

Measures
.Chart Review. For the sample of adolescents released in 1987-1988, a thorough chart review was conducted to obtain basic demographic information as well as information that might have been used to predict discharge to live outside one’s family of origin. In addition, information about the adolescents’ status at the time of discharge was also obtained.

Demographic data included information about the adolescent’s gender, race, and age. Other information available at entry that could be used to predict discharge to other than parents included information about: the adolescent’s home state, the person with primary financial responsibility for the adolescent’s treatment, parents’ marital status, physical custody of the adolescent, the adolescent’s major place of residence in the year before entry, residence immediately prior to admission, distance of this residence from the treatment facility, lifetime frequency of out-of-home placement, records of reported child abuse, and IQ score.
Data about condition at discharge included information about: the reason for withdrawal, discharge diagnosis, staff recommendations at discharge, person or agency to whom the client had been discharged, discharge residence, and distance of this residence from Devereux.

**In-Depth Interviews.** Interviews with the three adolescents who had been previously discharged from Devereux to live independently focused upon three aspects of current functioning so as to generate hypotheses about the needs of this population of adolescents. These included discussion of: (a) current independent living status, including questions about current residence and maintenance of tasks of independent living such as management of financial, educational/employment, and related tasks; (b) current social functioning, including friendships and availability of various sources of social support; and (c) other aspects of psychosocial functioning, including drug and alcohol use, impulse control, and ability to set and work toward life goals.

**Procedure**

Chart review was performed by a BA-level psychology intern, using a schedule with precoded categories for items. This same intern, under close supervision from the first author, also conducted qualitative interviews with the adolescents, who were first contacted by mail. Interviews were conducted at the subjects' convenience and with their informed consent. Subjects were paid $20 for the interviews, which lasted about one hour.

**RESULTS**

**Discharge Residence and Custody**

Information was obtained both on adolescents' discharge custody and discharge residence. Of the 169 adolescents on whom information was available, 48, or 28.4%, were not discharged to the custody of their parents. These 48 adolescents were most likely to be discharged to the custody of a social service agency (62.5%), to be emancipated (10.4%), to be discharged to the court system (12.5%) or to a relative (8.3%), or to be discharged under some other condition (6.2%).

These data on discharge custody provide only a partial picture, however. Although only 28% of all discharged adolescents were not discharged to the legal custody of their parents, many adolescents who were discharged to the custody of their parents were not discharged to live with them. Examination of the physical residence (as opposed to the legal custody) of discharged adolescents revealed that only 30.8% of all discharged adolescents went to live with their parents with the expectation that this arrangement would be permanent. An additional 14.8% of adolescents were discharged to live with their parents, pending placement in a different psychiatric hospital or residential treatment facility. Thus, even counting these adolescents who were living with their parents only temporarily, slightly
fewer than half of the sample (45.6%, n = 77) actually went to live with their parents at the time of discharge.

Of the adolescents not returning to live with their parents at discharge, 29 (17.2% of the entire sample) were discharged to a residential center or group home. Twenty-one adolescents (12.4%) were transferred to a psychiatric hospital. For 20 (11.8%) adolescents, the discharge residence was unclear at the time of discharge, typically because the discharge resulted from an elopement, or a sudden, unplanned withdrawal by parents or other guardians. The remaining adolescents were discharged to a variety of residences, including correctional facilities (3.6%), homes of relatives (2.4%), independent living facilities (1.2%), a residential school (1.8%), and foster homes (1.8%).

These data indicate that a substantial proportion of the adolescents discharged from a relatively typical set of residential psychiatric treatment facilities were not able to return (at least directly) to live with their parents. Clearly, not all of these adolescents will never be able to live with their families. What is both clear and consistent for the 54.4% of all discharged adolescents in this sample who were not discharged to a parent’s residence is that they will all be spending substantial parts of their adolescence living outside their families. Regardless of the specific setting to which they were discharged, these adolescents were likely to have somewhat different treatment needs while in residential care as a result of not living in a family environment during a significant portion of their adolescence. Therefore, we next examined possible factors that could identify this population at the time of entry into residential treatment.

**Predicting Discharge Outside the Family**

Chi-square analyses and t-tests were used to assess whether there were significant differences in entry characteristics between those adolescents who would be discharged to live with their parents and those who would not. Because families to which adolescents could return at least briefly between placements were considered to provide at least some support to the adolescent, the sample was broken down into adolescents returning to live with their parents (even if only temporarily) and those discharged to other residences.

As Table 1 shows, several factors were found to predict discharge to a residence other than with parents. These factors included whether parents were married at time of the adolescent’s admission, whether parents had primary financial responsibility for the admission, and whether the adolescent had been living with the parents immediately before entry. Adolescents who did not go to live with their parents at discharge were found to be slightly younger at entry. Adolescents with documented histories of abuse by parents were somewhat less likely to return to live with their parents than adolescents without such histories. Interestingly, adolescents who went to live with their parents had significantly higher IQ scores when tested while at Devereux than did adolescents who did not return to live with their parents.
Factors that did not predict discharge residence (not shown in Table 1) included the adolescent’s sex, race, frequency of prior out-of-home placements, length of stay at the residential center, and distance of the center from place of previous residence.

Next, those factors listed above that discriminated between adolescents who would and would not return to live with their parents were entered into a discriminant function analysis to examine the extent to which they could in combination predict adolescent’s discharge residence from data available at intake. This analysis revealed that for 64.6% of adolescents who would not live with their parents at discharge, this outcome could be successfully predicted from intake data. Given that an initial discriminant function tends to overestimate actual predictive abilities and that the 64.6% success rate is only slightly higher than the 51.6% success rate that could be obtained by simply predicting that all students would not return to live with their parents, these results suggest serious limitations to our ability to predict failure to live with parents at discharge.

**In-depth Interviews**

Information on each of the three in-depth interviews with former Devereux residents who were discharged to residences other than their families’ is presented below. The information begins with a description of the interviewee’s age and status at the time of the interview, is followed by the interviewee’s childhood history up through his or her discharge from Devereux, and concludes with a discussion of the interviewee’s current level of functioning. Finally, after

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<td>Age at entry to treatment (years)</td>
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describing the three interviews, we present a brief summary of themes that appeared consistently across interviews.

**Michelle.** Michelle, an 18-year-old white female, was interviewed one year after her discharge from the program at age 17, following a one-year stay. (Note: Names used are pseudonyms, and minor identifying details have been changed.)

Michelle’s family history included the loss of her natural father when he was deported for rape while she was still a toddler. Her mother remarried, and Michelle was sexually abused by her stepfather between the ages of 7 and 12. From age 14 on, Michelle lived with a friend of her maternal grandmother, who appeared to provide a somewhat stable environment. Not surprisingly, Michelle’s childhood was marred by psychiatric problems, including emotional lability, social isolation, and a history of depression and suicide attempts, which led to her placement at Devereux at age 16. Following her one-year stay at Devereux, Michelle was discharged to the home of her maternal grandmother’s friend, who had by that time become her legal guardian.

At her follow-up interview, Michelle was living in the dormitory of a small residential college during the academic year and with her legal guardian during summers. She described difficulties in handling stresses from her part-time job and difficulties in making friends. She noted that not only did she feel unprepared upon leaving residential treatment in most of the areas about which we queried her, but she felt that she had been held back from engaging in activities that would increase her social functioning. For example, she stated that during her inpatient treatment she was not permitted to get a part-time job, open a bank account, or take driver’s education courses.

Currently, Michelle appears to be coping adequately with school work and wants to go to graduate school after obtaining her BA. Michelle reported consuming moderate amounts of alcohol and marijuana. She sees her mother only several times a year, by her own choice, but she stated that she feels that someone is always “there” for her in her life, whether it be her guardian, her therapist, or her boyfriend.

**Matt.** Matt, a 21-year old white male, was interviewed three years after his discharge from residential treatment, at age 18, following a six-year stay.

Matt lived with his biological parents immediately before his entry into Devereux, although he had had multiple prior out-of-home placements in schools for emotionally and behaviorally disturbed children. He was placed at Devereux as a result of verbally and physically assaultive behaviors, which involved confrontations with peers and with his family. He also had some degree of learning disability. Matt’s parents maintained regular, though not extensive, contact with Matt during his stay at Devereux. After his graduation from the program, Matt’s parents wanted him to have more extensive vocational training, and so they helped to place him in a group apartment program that continued training in carpentry, which Matt had begun while at Devereux.

When interviewed, Matt had been living by himself in a small two-room apartment for the previous nine months. The areas in which he appeared least prepared
for independent living were social support and basic independent living skills. He was most concerned about his money management skills, although he noted that he had learned some of these while living in the group apartment. He had little idea of where to turn in case of legal, medical, or other kinds of problems, although it appeared he would be able to get some assistance in these areas from his parents if necessary. Matt also mentioned feeling quite socially isolated upon first leaving Devereux, and even at the time of the interview described having virtually no close friends. Matt reported only minimal and occasional use of alcohol and marijuana. He was working successfully as a carpenter, and definitely felt that this was the best aspect of the preparation for independent living that he received while at Devereux.

**Joe.** Joe, a 30-year-old married white male, was interviewed 12 years after he was discharged from Devereux at age 18, following a five-year stay.

Throughout his childhood, Joe lived with his mother and his natural father, who was alcoholic. Joe was placed in a special school at age 12, labeled "unmanageable," "truanting," and "wandering." He spent considerable time roaming the streets at night and was sexually assaulted at age 12. While in residential treatment, he was described as highly dependent upon the staff, who described him as "honest and trustworthy." At age 15, Joe was discharged briefly to his mother's custody, but his home situation was described as so chaotic that he was re-enrolled at Devereux. When he was discharged from Devereux at age 18, Joe went to live first with an uncle, then with his girlfriend's mother, followed by an unsuccessful six-week stay in the army. After this, Joe lived for the next five years in a YMCA.

When interviewed, Joe was married and living with his wife and three children. He reported that he had maintained contact with several Devereux staff for a number of years after his discharge, but otherwise had almost no friends. Joe sees his mother two to three times a month. Joe described himself as having been perfunctorily connected with several social services upon his discharge, but noted that none of these helped him very much. Devereux recommended that Joe receive therapy upon discharge, but this was not arranged for him, and he did not pursue it on his own. He stated that he learned most of his independent living skills on his own and from friends. Joe reported occasionally abusing alcohol and having great difficulty holding a steady job and completing his college education.

**Summary of Interview Data**

Although far from a statistically representative sample, these three young people, at three different points in their development, provide a sense of the diversity of experiences and backgrounds of young people leaving residential psychiatric treatment and not returning to live with their families. These interviews also share several consistencies that merit further consideration, since they appeared in spite of large differences in the interviewees' ages, backgrounds, and lengths of time in residential treatment.
The degree of social isolation reported by all three interviewees was striking. The reasons for this social isolation were also suggested by the interview data. Although independent living skills can be and sometimes were taught by programs following residential treatment, opportunities for guided interaction with peers in everyday social situations were much more rarely provided. Furthermore, skills at such interaction are not easily learned, nor can these skills be easily “made up for” later. The lack of social skills itself may promote social isolation, which in turn only worsens the cycle. In fairness, difficulties in social interaction are a common problem of many persons who require extensive psychiatric treatment. Yet so are difficulties with impulse control, career progress, and avoidance of self-destructive behaviors. Although these other problems are also seen to some degree in the interviews, they are not nearly so consistently present as reports of social isolation.

A second consistent theme of the interviews was the lack of preparation for independent living skills experienced by all three interviewees. One young person stated that she felt hampered by her residential program in trying to acquire these skills. This comment likely reflects less the program she was in than the nature of residential psychiatric treatment in adolescence. It may be a difficult task for any full-time residential psychiatric treatment program for disturbed adolescents to provide opportunities to learn to drive, open bank accounts, etc. Yet, undoubtedly, these tasks need to be accomplished. Unlike problems with social isolation, however, the young people interviewed in this study had overcome their deficits in independent living skills at least somewhat successfully.

A final, somewhat surprising finding from interviews was that all three interviewees had had significant contact with their families (or permanent legal guardians) after their discharge. Even when residence with parents was not possible, significant interaction and, in some cases, occasional aid from family members appeared to occur.

DISCUSSION

The results of this study suggest a clear opportunity for residential psychiatric treatment facilities to enhance their services by better attending to the developmental needs of the adolescents in them who cannot return to live with their families. Our comprehensive survey of a system of 11 such facilities revealed that over half of adolescents discharged from these facilities do not return to live with their parents. Although our data suggest some potential to predict which adolescents will be discharged outside their family, such predictions appear far from precise. Finally, interviews with former adolescent residents of residential facilities revealed several unmet needs that appeared to stem from not having a family with whom to live upon discharge. Each of these findings, and their implications and limitations, will be discussed in turn below.

The large number of adolescents who were not able, for a variety of reasons, to live with their parents upon discharge from residential facilities suggests that these
facilities may have a significant role to play in preparing adolescents for eventual independent living. Of course, it is not appropriate to generalize directly from these data to the population of adolescents in residential treatment. Unique features of The Devereux Foundation centers may affect the proportions of adolescents who do not return to live with their families after residential treatment. For example, The Devereux Foundation draws residents from a wide geographic area, a factor that may influence the composition of the adolescents in this sample. Adolescents entering out-of-state residential treatment programs may be more likely to lack strong family connections, and may have more difficulty maintaining any family connections they do have over long distances.

However, while the generalizability of this sample to larger populations remains unclear, the number of young people released in just this subset of Devereux facilities comprises approximately 1% of the total number of all young people who enter residential psychiatric treatment each year. Thus, the sample for this study is a substantively important one on its own. Although this study does not provide a basis for estimating precise percentages, it certainly suggests the likelihood that the number of adolescents discharged from residential psychiatric treatment each year who cannot return to live with their families is quite substantial. This study also found that it was relatively difficult to predict at program entry which adolescents would not be returning to live with their families at program discharge. Although this study identified several promising predictors, such as parents’ marital status, financial responsibility for treatment, and whether the adolescent was living with parents immediately before treatment, the overall predictive power of these factors was not high. Of course, one might expect predictive power to increase with more knowledge of the young person, and one of the limitations of this study was its reliance on data collected primarily from chart reviews. Yet, at the time of program entry, when treatment plans are being devised, information on adolescent residents is often quite limited. Also, whether a young person returns to live with his or her family upon discharge depends at least in part on characteristics of the family, which often change over the course of treatment. In brief, this study suggests that predicting which young people will not return to live with their families at discharge may be difficult given the information available at program entry.

If replicated, this finding has serious implications for the nature of residential psychiatric treatment of adolescents, in that it suggests that all adolescents in residential treatment might profitably be targeted for services geared toward helping them eventually live independently. Also, the substantial period of time spent in residential treatment by young people who eventually returned to their families suggests that even adolescents returning to live with their families may have deficits in independent living skills, because they will have missed numerous opportunities to gain these skills in their daily lives. Thus, both predictive and preventive considerations suggest the value in using residential treatment to address the needs of adolescents who will not be able to live in normal family circumstances for substantial parts of their adolescence.
The hypothesis-generating portion of this study suggested that the difficulties faced by adolescents who do not return to their families after discharge are substantial. In particular, the lack of social skills and the social isolation seen in former residents of residential facilities suggest a need to design residential psychiatric treatment programs to develop residents' skills in meeting and making friends with their peers outside a residential facility. Several promising areas of recent work that focus explicitly on helping adolescents develop skills in social interactions include social skills curricula, and therapies based explicitly on peer interactions (Goldstein, Sprafkin, Gershaw & Klein, 1980; Selman & Schultz, 1990).

In addition, qualitative interview data also suggested that adolescents receive little direct preparation for independent living in the context of residential treatment programs. It might be argued that many adolescents in residential treatment end up living in group homes and other residential settings before eventually living on their own. However, the case studies presented here show that the quality of direct training in independent living skills that adolescents ultimately receive can be uneven at best. Allowing an adolescent to progress to within a few months of beginning independent living while hoping that a later program will provide needed skills thus appears to be a risky strategy. Significant efforts have been made within foster-care and group-home programs to develop resources to aid adolescents in the transition to independent living (see Correla, 1986); this study suggests the importance of developing and using these resources within residential psychiatric facilities serving adolescents.

Providing adolescents with training in addressing social and practical issues related to independent living can also facilitate their development in other areas. For example, both poor interpersonal negotiation strategies and a low sense of self-efficacy might be enhanced by such training and have been related to serious adolescent problem behaviors (Allen, Leadbeater, & Aber, 1990; Leadbeater, Hellner, Allen, & Aber, 1989). In addition, while the adolescent struggle for autonomy from adult influences might otherwise make therapeutic interventions difficult with this population, provision of the types of training described above may enhance therapeutic relationships by making clear that the goal of a treatment program is to increase, not threaten, the adolescent’s developing sense of autonomy (Allen, Aber, & Leadbeater, 1990).

In summary, the findings of this study suggest a pressing need for enhanced services to prepare the 20,000 adolescents who enter residential psychiatric treatment each year for eventual independent living. Further research is now required to explore more carefully the hypothesis, generated by this study, that adolescents leaving residential treatment and not returning to their families have substantial unmet needs in social and independent living skills. These tentative findings certainly fit our knowledge of how services are provided to this population. Nevertheless, comparison of adolescents leaving residential treatment who do and do not return to their families will allow a more careful distinction to be made between the general needs of emotionally disturbed adolescents and the specific
needs of this population. It is possible that such needs do not differ greatly, or that other factors, such as length of time outside a normal family situation, will also be critically important. Such knowledge is needed to begin tailoring residential psychiatric programs not just to the clinical/psychiatric needs of their residents, but to some of their normal developmental needs as well. Both the proportion of this sample not returning to live with their families, and the potentially tremendous magnitude of the problems they face, suggest that these needs must not be ignored.

REFERENCES


**Acknowledgments.** This study was conducted with the funding and support of The Devereux Foundation. The authors would also like to thank Stephen Strzelecki for his assistance in all phases of this project.

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