The Coping and Adaptation of Youth After Discharge from Residential Treatment: Mothers’ Perspective

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ABSTRACT

THE COPING AND ADAPTATION OF YOUTH AFTER DISCHARGE FROM RESIDENTIAL TREATMENT: MOTHERS’ PERSPECTIVE

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Approximately 20% of youth are diagnosed with a mental health disorder; emotional behavioural disorders (EBDs) are amongst the most prevalent mental health disorders (Pastor, Reuben, & Duran, 2012; Waddell et al., 2002). High risk youth with EBD may access residential treatment (RT) which provides a secure setting where youth stay long-term to receive treatment for their EBD symptoms. The purpose of this study was to explore mothers’ reports on the transition home and how their child coped with the transition experiences after RT. Ten mothers of youth discharged from RT participated in a semi-structured interview 4 weeks post-RT. Mothers commented on some irritability, unpredictability and some decline in functioning seen in their child. Several coping strategies were reported: cathartic activities, social support, avoidance, social isolation and coping strategies acquired from RT. The mothers’ reports suggested that youth struggled to manage the transition without extensive formal and informal support networks.
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List of Abbreviations

EBD, Emotional behavioural disorder
RT, Residential treatment
ADHD, Attention deficit hyperactivity disorder
ODD, Oppositional defiant disorder
CD, Conduct disorder
APD, Antisocial personality disorder
IHT, Intensive home treatment
RAM, Roy Adaptation Model
CAS, Children’s Aid Society
SDQ, Strengths and Difficulties Questionnaire
SPSS, Statistical Package for Social Sciences
DBT, Dialectical behavioural therapy
CYW, Child and Youth Worker
IEP, Individualized education plan
**Introduction**

Mental health is at the forefront of scientific research. A critical component of mental health is the ability to cope with challenge (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen 1986). Challenges and obstacles can manifest in various life domains, such as work, education, relationships and family life. Inability to cope with challenge could lead to mental health problems. Conversely, the presence of mental health problems may impede or challenge one’s coping abilities. Mental health problems often begin manifestation in childhood and approximately 50% of mental health disorders are present by adolescence (Kessler et al., 2005; Paus, Keshavan, & Giedd, 2008). An estimated 1.1 million Canadian children experience a mental health problem (Waddell, Offord, Shepherd, Hua, & McEwan, 2002). Scientific research should be focused on this vulnerable population to further understanding of mental illness risk-factors, treatment options and post-treatment care. The present study was focused on youth with emotional and behavioural disorders (EBD) who have accessed residential mental health treatment and intended to return to their family of origin post-discharge. Specifically, the focus was on how parents report their child managed the initial transition home after residential treatment.

EBD is among the most common chronic conditions in children and youth (Pastor et al., 2012). EBD encompasses a variety of mental health disorders including attention deficit hyperactivity (ADHD), oppositional defiant disorder (ODD), conduct disorder (CD), anxiety disorders and depressive disorders (Egger & Angold, 2006). These disorders can be classified as internalizing disorders (emotional disorders) or externalizing disorders (behavioural disorders) (Egger & Angold, 2006). Internalizing symptoms include how youth personally feel or think, such as excessive feelings of sadness, anxiety or fear (Egger & Angold, 2006). Externalizing
symptoms pertain to how youth outwardly display themselves, for example being noncompliant or hostile (Egger & Angold, 2006). The EBDs of these high-risk youth inevitably affect their parents, who form their own opinion on the youth’s progress. The current study is focused on parents’ perceptions of how their children with EBD coped after accessing mental health treatment.

**Adolescence**

**Prevalence.** Approximately 50% of lifetime mental health disorders begin by adolescence (Kessler et al., 2005). Mental health disorders are also quite prevalent in adolescents. The reported prevalence rates of mental health disorder in adolescents range from 15% to 22% (Merikangas et al., 2010; Waddell & Shepherd, 2002; Waddell et al., 2002). Furthermore, 14% of adolescents struggle with a mental health disorder with clinically significant impairment in functioning (Waddell et al., 2002). Prevalence rates are likely to be underestimated because adolescents who are undiagnosed may not have been included in the estimate (Mash & Barkley, 2003). EBDs have been reported as the most common disorders in adolescents, including anxiety, conduct, attention and depressive disorders (Waddell & Shepherd, 2002). Such mental health disorders place adolescents at risk for suicidal attempts (Andrews & Lewinsohn, 1992); the moderately high prevalence rates are a cause of concern. Further, an adolescent with a mental health disorder is likely to experience comorbidity or have another diagnosed psychiatric disorder (Pine et al., 1998). Increases in conduct and emotional problems in adolescents have been observed in a 25-year period (Collishaw, Maughan, Goodman, & Pickles, 2004). Overall, reported prevalence rates of mental health problems in adolescents seem to have increased over time (Polanczyk, Salum, Sugaya, Caye, & Rohde,
Research should subsequently be focused on adolescence to broaden understanding of adolescent mental health.

**Adolescent developmental trajectories.** Mental health during adolescence, in particular, warrants scientific inquiry. Adolescence has been noted as a period of time when individuals begin to explore their identity and sense of self (Masten & Coatsworth, 1998; Steinberg & Morris, 2001). The formation of a cohesive sense of self has been considered a developmental task during adolescence (Masten & Coatsworth, 1998). This developmental task coincides with a need to form friendships, become involved in extracurricular activities and transition successfully into secondary school (Masten & Coatsworth, 1998). Adolescence is a transition phase between childhood and adulthood. Adolescents seek autonomy but may not be fully independent or ready for adult responsibilities (Cicchetti & Rogosch, 2002). Psychological autonomy can be regarded as a developmental task during adolescence or a precursor for adulthood (Noom, Deković, & Meeus, 2001). This need for autonomy may lead to tension or conflict between parents and their adolescent children because some parents want to retain control (Smetana, 1989). Conflict in the parent-child relationship is common during adolescence (Allison & Schultz, 2004). It is important to explore the mental health of adolescents as they struggle with normative internal and external conflict. Furthermore, mental health problems in adolescence also increase the risk of mental health problems in adulthood (Pine, Cohen, Gurley, Brook, & Ma, 1998). For example, Bardone, Moffitt, Caspi, Dickson, and Silva (1996) found that depression in adolescent girls often persisted into adulthood. Similarly, adolescent girls with conduct disorder were likely to develop symptoms of antisocial personality disorder by 21 years of age (Bardone et al., 1996). Several mental health disorders are persistent over time (Cohen,
Cohen & Brooks, 1993); therefore, it is important to focus on adolescence since many lifetime mental health disorders begin during adolescence (Kessler et al., 2005).

**Adolescence as a sensitive time period.** Adolescence has been noted as a developmental period for neurological processes vital to higher cognitive functions taking place during adulthood (Yurgelun-Todd, 2007). For example, brain regions involved in executive functions, such as emotion regulation and attention shifting, undergo critical neurological changes (Yurgelun-Todd, 2007). Such changes correspond to the emotional arousability, risk-taking and behavioural problems that are commonly seen during adolescence (Yurgelun-Todd, 2007). Noticeably, these behaviours can be characteristic of EBD (Egger & Angold, 2006). Thus, impairments in mental health during adolescence have the potential to critically alter normative brain development. These alterations could lead to greater negative outcomes or atypical cognitive functioning. Nelson, Leinbenluft, McClure, and Pine (2004) cited adolescence as a sensitive time period for the neurological development of social behaviour processing. Alterations to these neurological processes could contribute to the onset of anxiety and mood disorders in adolescence (Nelson et al., 2005). As significant neurological development takes place during adolescence, it can be considered a sensitive time period for mental health disorders.

**The Etiology of Mental Health Disorders**

The etiology of mental health disorders is multifaceted. Mash and Barkley (2003) suggested a developmental systems perspective when reviewing child and adolescent psychopathology. From this perspective, interactions between the child’s development, context and life events are underscored. Such a complex system of interactions creates some difficulty in
understanding the etiology of mental health disorders. The exact etiology for mental health disorders is still unknown. Nonetheless, recognition of risk factors is useful for individual and societal development (Mash & Barkley, 2003). Several factors associated with mental health disorder have been reported. These factors can be considered psychological, biological and environmental. Additionally, the interactions between these factors are equally relevant (Dodge & Pettit, 2003). However, research findings should be interpreted with caution. A relationship does not imply a causal link. Findings are regarded as risk factors or predisposing factors for mental health disorders. All individuals who experience one type of risk factor do not develop a mental health disorder, corroborating the role of multiple factors (Sroufe & Rutter, 1984).

Nonetheless, understanding the etiology of mental health disorders provides a framework for interpretation of literature regarding mental health treatment and post-treatment care. The current study was focused on youth with EBD; therefore, this section is focused on the particular risk factors for EBD.

**Psychological risk factors.** Psychological risk factors relate to an individual’s cognitions, affect or emotions. Stress, cognitive processes and psychological history were heavily outlined in the developmental psychopathology literature.

**Stress and adaptation.** Sensibly, psychological stress predicts psychopathology in childhood and adolescence (Compas, Connor-Smith, Saltzman, Thomsen, & Wadsworth, 2001). However, psychological stress can be caused by events of varying severity. For example, parental marital conflict and severe poverty can both contribute to risk factors associated with mental health disorders (Mash & Barkley, 2003). In this regard, it is difficult to segregate an environmental factor from a psychological factor. However, Sroufe and Rutter (1984) emphasized the importance of psychological adaptation in response to stress. Maladaptation can
be linked to disorder at the time of the stressful experience or alter behavioural patterns which can later foster disorder (Sroufe & Rutter, 1984). Further, psychological responses during childhood may foster mental health disorder at a later time. For example, a lack of control over emotions and attention at 3 years of age has been shown to moderately correlate ($r=0.3$, $p<.001$) with externalizing behaviour problems at 11 years of age (Caspi, Henry, McGee, Moffitt, & Silva, 1995). Therefore, an individual’s response to stress is pertinent (Dodge & Pettit, 2003).

**Cognition.** Cognitive appraisal, or how one thinks and perceives, of a stressor can interact with other risk factors and influence the development of mental health disorders (Mash & Barkley, 2003). For example, cognitive appraisal may interact with behavioural patterns to further symptoms of depression (Mash & Barkley, 2003). However, a variety of cognitive processes can influence one’s predisposition to a mental health disorder. For instance, knowledge acquisition can influence one’s representations of past memories, which can impact future behavioural patterns associated with mental health disorders such as conduct disorder (Dodge & Pettit, 2003). In addition, one’s intrinsic temperament has been linked with the risk of mental health disorders. For example, a negative temperament, or being temperamentally sensitive to negative stimuli, may influence one’s vulnerability to disorders such as depression and anxiety (Clark, Watson, & Mineka, 1994). Cognitive processes and temperament surely influence the development of mental health disorders in adolescents.

**Mental health history.** Another fairly large risk factor pertains to one’s psychological history. Previous mental health problems may predispose an individual to mental health problems at a later time (Mash & Barkley, 2003). However, a subsequent mental health problem can be a different kind of disorder or elicit different symptoms than before. Meta analytic data indicated a slightly greater risk of depressive symptoms in children aged 4 to 18 years with a
chronic medical illness compared to healthy children (Bennett, 1994). While there may be a relationship between physical health risk factors and mental health problems, it is likely indicative of psychological risk factors. Chronic medical illness could lead to feelings of helplessness or decreased socialization, which may foster depressive symptoms (Bennett, 1994). Comorbidity refers to the presence of one or more diagnosable mental health disorders at a given time (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003). For example, depression, anxiety and conduct disorder have frequently been shown to co-occur (Holmes, Slaughter, & Kashani, 2001). Research findings have indicated that conduct disorder can occur secondary to depression and anxiety (Holmes et al., 2001). However, conduct disorder may occur secondary to other disorders because there are many environmental contributions to the onset of conduct disorder (Holmes et al., 2001).

Additionally, the presence of mental health disorders in parents may also be considered a risk factor for mental health disorders in children. For example, Lahey et al. (1988) reported a higher incidence of conduct disorder symptoms in children of parents with antisocial personality disorder (APD) than children of parents without APD ($F=12.61$, $p<.001$). More specifically, paternal mental health problems have been noted as a risk factor for anxiety disorders; maternal mental health problems have been noted as a risk factor for oppositional defiant and depressive disorders (Velez, Johnson, & Cohen, 1989). In examining the etiology of adolescent mental health disorders, it is important to understand individual and family mental health history.

**Biological risk factors.** Biological factors pertain to genetic and physiological influences on one’s predisposition to mental health disorders.

*Genetics.* Genetic contributions to mental health disorder are significant. Meta analytic data suggest that up to 32% of variance in antisocial behaviour can be explained by genetics
Genetic influences in the development of depression vary between studies; however, moderate effects have been cited (Mash & Barkley, 2003). Thapar and McGuffin (1994) found greater heritability of depressive symptoms in adolescents compared to children. Rutter and Sroufe (2000) highlighted that genetic factors are probabilistic, not deterministic. However, genetic composition may influence one’s susceptibility to disorder (Rutter & Sroufe, 2000). The environment may also influence the expression of genes. For example, the early environment can change genetic processes, which may influence the risk of depression later in life (Dalton, Kolshus, & McLoughlin, 2014). In this regard, it can be difficult to segregate genetic and environmental factors. The presence of particular genes does not cause disorder; however, genetic influences on mental health appear important.

**Physiology.** Physiological processes can influence susceptibility to mental illness (Sroufe & Rutter, 1984). Relevant physiological processes can pertain to hormonal regulation and neural activity. For instance, Birmaher et al. (2000) reported a slightly decreased secretion of growth hormone in youth at risk for depression compared to low-risk youth. Further, lower levels of growth hormone have been shown to persist in youth diagnosed with depression (Dahl et al., 2000). These findings could indicate a risk factor or perhaps a marker of depression. However, the role of hormones in mental health disorder is depicted. Neural activity can include neurochemical activity and neural functioning. For example, a history of parental aggression may influence serotonin functioning in boys with ADHD (Halperin et al., 1997). Decreased blood flow to the prefrontal brain region could also be linked in the etiology of ADHD (Mash & Barkley, 2003). Overall, there seems to be some neurobiological basis to mental health disorder.

**Development.** Processes associated with development or maturation may also influence mental health. Generally, the prevalence of mental health disorder tends to increase with age
during adolescence (Merikangas et al., 2010). Additionally, research results tend to show higher rates of internalizing disorders in females than males. For example, the prevalence of anxiety disorders was shown to be 1.5 times higher in female adolescents than male adolescents (Merikangas et al., 2010). Conversely, males often have higher rates of externalizing disorders than females (Sroufe & Rutter, 1984). For instance, ADHD was shown to be 3 times greater in male adolescents than female adolescents (Merikangas et al., 2010). While gender differences could be attributed to some developmental differences, socialization likely plays a role as well (Sroufe & Rutter, 1984).

Puberty may also influence one’s chance of mental health disorder. For example, when compared to girls who experienced late puberty, girls who experienced early puberty were shown to be 2.7 times more likely to have depression and 3.4 times more likely to have anxiety during late adolescence (Kaltiala-Heino, Marttunen, Rantanen, & Rimpelä, 2003). Generally, adolescent girls who experienced early puberty tended to have more internalizing symptoms and externalizing symptoms than girls who experienced late puberty (Kaltiala-Heino et al., 2003). Adolescent boys who experienced early puberty only displayed more externalizing symptoms compared to boys who experienced late puberty (Kaltiala-Heino et al., 2003). Development and maturation likely contribute to the etiology of mental health disorder.

**Environmental risk factors.** Other factors play a role in mental illness, many of which could be considered environmental. The environment can include one’s surrounding neighbourhood and home environment – both of which influence the development of mental health disorders (Rutter & Sroufe, 2000). In twins, 43% of variance in antisocial behaviour is due to non-shared environmental factors (Rhee & Waldman, 2002). However, intrapersonal factors influence one’s environment, leading to a complex set of risk factors. For example, one’s
dispositional temperament may lead one to choose a particular environment that could increase the risk of mental illness. Regardless, the environment can influence mental health.

**Community risk factors.** Surrounding neighbourhoods include the local community; for instance, how one is treated by peers or teachers (Rutter & Sroufe, 2000). Mash and Barkley (2003) highlighted two peer-related risk factors: peer rejection in childhood and association with deviant peers in adolescence. These two factors often related to conduct and oppositional deviant disorders (Mash & Barkley, 2003). Peer rejection in childhood has been linked to ADHD symptoms (Hinshaw & Melnick, 1995), although children with behavioural disorders are often rejected by peers (Dodge et al., 2003). Peer rejection in 16-year-old adolescent boys has been shown to correlate with greater depressive ($r=.17$, $p<.01$) and anxiety symptoms ($r=.27$, $p<.01$) at 19 years of age (Fite, Rubens, Preddy, Raine, & Pardini, 2014). Additionally, association with deviant peers among adolescents with ADHD may pose a risk factor for future mental health problems such as substance use (Marshal, Molina, & Pelham Jr., 2003). Bullying may also be an important risk factor. Copeland, Wolke, Angold, and Costello (2013) explored the rates of adolescent psychiatric disorder in relation to experiences with bullying. In comparison to adolescents who were neither victims or bullies, victims of bullying were 4.7 times more likely to have an anxiety disorder while bullies were 4.1 times more likely to have antisocial personality disorder. Moreover, adolescents who were both bullies and victims had the highest rates of all anxiety disorders, depressive disorders and suicidality (Copeland et al., 2013). Peer rejection and peer victimization have been implicated as risk factors for EBDs.

Where an individual resides can also play a role. Aneshensel and Sucoff (1996) described how perception of a neighbourhood as dangerous can influence adolescent mental health. Greater perceived danger in a neighbourhood was shown to be predictive of greater symptoms of
depression ($\beta=.107, p<.05$), conduct disorder ($\beta=.214, p<.001$) and anxiety ($\beta=.160, p<.001$). Further, greater feelings of social cohesion can be predictive of fewer incidences of depression ($\beta=-.123, p<.001$; Aneshengsel & Sucoff, 1996). Community violence may contribute to emotional desensitization to violence; this desensitization may relate to later externalizing problems in youth (Mrug, Madan, & Windle, 2016). Culture can also interact with a multitude of these factors (Dodge & Pettit, 2003). Thus, a variety of community factors influence adolescent mental health.

**Familial risk factors.** Many factors contribute to the development of EBDs; however, the role of family environments should be underscored. Poor family functioning and poor parental behaviours appear to be highly relevant to the development of EBDs. Family dissolution, poor adult-child bonding and negative parenting styles are significant risk factors for the development of mental health disorders (Moffitt, 2005). For example, poor parental supervision of boys at 10 years of age was shown to correlate ($r=-.34, p<.001$) with greater antisocial behaviour at 12 years of age (Dishion, Patterson, Stoolmiller, & Skinner, 1991). Greater parental monitoring behaviours have also been shown to correlate with fewer externalizing behaviours ($r=-.18, p<.001$) during early adolescence (Pettit, Laird, Dodge, Bates, & Criss, 2001). Parenting style can also be significant. Individuals with early onset and persistent subtypes of antisocial behaviour tend to have more neglectful parents than individuals with other subtypes of antisocial behaviour (Aguilar, Sroufe, Egeland, & Carlson, 2000). Serious family discord has been consistently shown to contribute to the development of disruptive disorders (Rutter, 1994). Family functioning appears highly pertinent influence one’s risk for EBDs.

The highest symptom severity displayed by youth who accessed RT has been reported to be conduct disorder, though most symptoms (e.g., depression and attention difficulties) were also
in the clinical range (Preyde et al., 2011c). Family life has been regarded as one of the most significant factors related to the development of conduct disorder (Holmes et al., 2001). Avoidant attachments and poor parenting have also been shown to contribute to later conduct problems (Sroufe, Fox, & Pancake, 1983; Waddell, McEwan, Shepherd, Offord, & Hua, 2005). These poor parenting behaviours can include parental rejection, physical violence and inconsistencies in parental figures (Jouriles, Murphy, & O’Leary, 1989; Rutter, Giller, & Hagell, 1998; Widom, 1989). There are several kinds of familial risk factors; however, parental violence and neglect are noteworthy risk factors (Holmes et al., 2001). These family risk factors may suggest some instability or poor functioning within the families of youth with EBD. In fact, residential instability has been shown to predict adolescent delinquency ($\beta=.19$, $p<.01$) and status offenses ($\beta=.37$, $p<.001$; Herrenkohl, Herrenkohl, & Egolf, 2003). Complex factors contribute to EBDs seen in youth with much research corroborating the role of the family environment.

That is not to say that parents are to blame for the onset of EBD in their children. The contextual factors are substantial. It is suggested that some parents may adjust better to their children and life stresses, depending on their own personalities. Thomas and Chess (1977) suggested that a “goodness of fit” between the personalities of parents and their children may reduce the risk of psychological disorder. For example, children with difficult temperaments have been shown to be at greater risk for behavioural disorders than children with easy temperaments (Thomas, Chess, & Birch, 1968). However, not all children with difficult temperaments develop behavioural disorders. This could be due to a “good fit” between difficult children who have consistent or adaptable parents. “Poorness of fit” may increase risk of psychological disorder. For example, difficult children who have impatient or inconsistent parents may be at greater risk (Thomas & Chess, 1977). Although there are many risk factors,
family functioning is highly pertinent to the etiology of EBDs.

Residential Treatment

Treatment for youth with EBD. Mental health treatment for youth with EBD may be pivotal to their future life trajectory. Adolescents with EBD are at risk for negative outcomes, such as being unemployed or engaging in criminal behaviour (VanderStoep et al., 2000). Furthermore, these youth are at risk for chronic unemployment and may remain in constant contact with the judicial system (Wagner, Newman, Cameto, Garza, & Levine, 2005). Additionally, these youth may not finish high school or may disconnect from their communities (Wagner et al., 2005). These outcomes could be partially attributed to a lack of social, behavioural, academic or professional skills (Lane & Carter, 2006). A variety of services may be needed for youth to experience positive outcomes, such as being independent and self-sufficient. The required services may include mental health treatment, counselling, family support, case management or substance abuse treatment (Lane & Carter, 2006). While the need for treatment is recognized, less than 25% of youth receive treatment (Waddell et al., 2005). Treatment options for youth with EBD range from less intrusive options to more intrusive options. Less intrusive options can include outpatient therapy, family-based therapy or community-based services (Wilmshurst, 2002). More intrusive options can include intensive home treatment (IHT), residential treatment (RT) or psychiatric inpatient care (Wilmshurst, 2002). The current research was focused on youth with EBD who have accessed RT, one of the most intensive options.

What is residential treatment? RT provides a secure and stable setting where youth reside while they receive treatment for their mental health disorders. The duration of treatment can be around 7 to 9 months (Preyde, Frensch, Cameron, Hazineh, & Riosa, 2011b). The youth
often stay on-site for the week and may visit their family on weekends. During the week, the youth will often attend an on-site school while receiving treatment. Some youth may attend their regular public school, while others may attend an alternative school or the on-site school. Treatment is often multidisciplinary, potentially involving social workers, psychiatrists and teachers (Larzelere et al., 2001). Additionally, treatment plans are created for youth to cater to individual needs and can range from individual therapy to group therapy.

**Youth accessing RT.** Taking care of youth with EBD can be straining for a caregiver (Brannan & Heflinger, 2001), which may ultimately lead to their admission into RT. RT is typically reserved for those youth with moderate to severe EBD who were unsuccessful with less intensive treatments (Wells & Whittington, 1993). Many youth entering RT struggle with disruptive, externalizing and internalizing disorders; these disorders often include conduct, attention, and depressive disorders, respectively (Connor, Doerfler, Toscano, Volungis, & Steingard, 2004; Preyde et al., 2011c; Preyde et al., 2011b). RT has been noted to serve very troubled youth and has been regarded as the last service option (Yelton, 1993). Further, RT may be the only feasible option considering the youth’s functioning or living conditions. Otherwise, it would be preferable to receive at-home treatment or community-based services to preserve the youth’s normative environment (Yelton, 1993). Hence, the population of youth accessing RT is distinct among youth with mental health disorders.

Youth entering RT tend to face several hardships in their family life. Research results show that many youth entering RT come from divorced families, blended families, single-parent families or adoptive families (Preyde, Cameron, Frensch, & Adams, 2011a). Families of children accessing RT may have a history of abuse, mental illness, substance use or violence (Connor et al., 2004; Griffith et al., 2009; Wells & Whittington, 1993). Generally, the quality of the home
environment appears limited in terms of how the family functions as a unit or parenting practices. Family functioning includes a variety of factors such as problem solving, communication, affective responsiveness, affective involvement and behaviour control (Epstein, Bishop & Levin, 1978). In a sample of 7270 youth, Sunseri (2004) reported 23% of families were of low functioning and 47% of families were of intermediate functioning at admission. Moderate impairment in family functioning has been reported at admission; for example, family members may behave poorly towards one another or not adhere to rules and expectations (Preyde et al., 2011c). Preyde et al. (2011c) reported 44% of families were still functioning in the clinical range at a 12 to 18 month follow up, based on the factors described by Epstein et al. (1978). Such research results speak to the persistence of poor functioning amongst the families of youth accessing RT.

Families of youth accessing RT tend to show limited positive parenting techniques and conflict between parents may interfere with the family’s functioning (Griffith et al., 2009). Parents have also self-reported a need to learn about discipline, maintain consistency in discipline and control their emotions (Griffith et al., 2009). The families of youth accessing RT tend to be less cohesive and less adaptable to change (Wells & Whittington, 1993). Additionally, these families experience multiple stressors and tend to score high on measures of family stress compared to nonclinical families (Wells & Whittington, 1993). The families of youth accessing RT likely do not function adequately enough to deal with the high amount of stress. The poor functioning of these families may be exacerbated by financial problems, which are common amongst this sample (Griffith et al., 2009). Instability and hardship appear common in the family lives of youth accessing RT.
Youth accessing RT may have a legal history of abuse or neglect; therefore, the families may have come in contact with the child welfare system (Baker, Archer, & Curtis, 2007). Estimates of youth accessing RT who are in the care of biological parents have been reported between 45% to 57% (Connor et al., 2004; Preyde et al., 2011c; Wells & Whittington, 1993); however, being in the care of a biological family does not imply the family has not interfaced with the child welfare system. The current study was focused on youth who intended to return to their family home and were not in the care of the government at discharge. It appears that a common trend among the lives of these youth is instability in terms of accessing different treatment or home placements (Trout et al., 2009). Cumulatively, the significant risk and instability these families experience could make them difficult to recruit for research purposes.

**Outcomes after RT.** As RT can be very intensive, it is critical to examine the outcomes after RT to understand youth functioning post-RT.

**Psychosocial functioning.** Psychosocial functioning refers to how youth function in various life domains such as the home, school and community. Lyons, Woltman, Martinovich, and Hancock (2009) examined youth psychosocial functioning after a one year stay in RT. Overall, there were improvements in overall life domain functioning at discharge from RT (Lyons et al., 2009). Helgerson, Martinovich, Durkin and Lyons (2007) also found increases in functioning across 62 different residential treatment facilities in Illinois. However, the rate of improvement differed between residential treatment facilities (Helgerson et al., 2007). Meta analytic data have supported such improvements in psychosocial functioning, which the authors claim to be a result of the treatment at residential centres (Knorth, Harder, Zandberg, & Kendrick, 2008).
Similarly, Preyde et al. (2011c) reported improvements from admission to discharge regarding youth functioning at school/work ($t=5.18$, $p<.001$), home ($t=7.04$, $p<.001$) and in behaviour towards others ($t=8.31$, $p<.001$). Some sustainable improvements in psychosocial functioning and mental health have been reported in the long-term after discharge (Larzelere et al., 2001; Nijhof, Otten, & Vermaes, 2014; Preyde et al., 2011c). However, it is important to highlight that there is variation in psychosocial functioning after RT. Some youth maintained psychosocial improvements at a two-year follow up, but improvements may not be maintained longitudinally for other youth (Preyde et al., 2011c). While gains in psychosocial functioning have been reported for many youth, some youth were still functioning within the clinical range after discharge (Preyde et al., 2011b). Further, some youth did not show improvements in psychosocial functioning and a few youth regressed in psychosocial functioning after RT (Preyde et al., 2011b). Hence, youth may still need other less intensive mental health treatments after discharge from RT. In sum, some youth show improvements in functioning after RT while other youth may not improve or regress in psychosocial functioning.

**Symptom severity.** RT has been shown to improve symptoms associated with the emotional and behavioural disorders of youth. Generally, youth problem severity has been shown to significantly improve from admission to discharge (Kapp, Rand, & Damman, 2015). Many youth accessing RT struggle with externalizing disorders and internalizing disorders (Connor et al., 2004; Preyde et al., 2011b; Preyde et al., 2011c). Therefore, externalizing symptoms (e.g. violent behaviours or hyperactivity) and internalizing symptoms (e.g. excessive sadness or anxiety) are of particular interest. Larzelere et al. (2001) found improvements in externalizing ($F=11.27$, $p<.001$) and internalizing behaviours ($F=9.87$, $p<.001$) from admission to discharge. These behavioural advancements were maintained at a long-term follow up anywhere from 6 to
21 months (Larzelere et al., 2001). Similar results were reported by Preyde and colleagues (2011b). At discharge from RT, youth showed some improvements in internalizing and externalizing symptoms. However, improvements were not consistent between youth. While improvements were made, youth were still struggling within a clinical range, especially for externalizing symptoms (Preyde et al., 2011b). The severity of symptoms suggests that youth still struggle with mental health symptoms after RT and may require other treatment services.

**Community life.** The ability for youth to leave RT and reintegrate into the community is significant. Many youth accessing RT have conduct disorder (Preyde et al., 2011b); their functioning in social contexts, such as the community, home and school, is highly pertinent to their future success. Cameron, Frensch, Preyde, and Quosai (2011) reported improvements in youth on scales measuring community conduct at a 12 to 18 month follow up, compared to admission. While these improvements were statistically significant, youth were shown to have clinically significant results. In addition, a greater proportion of youth had contact with the law at follow up (49%) than at admission (35%). The delinquent behaviour of youth post-RT suggested some difficulty adapting to the community (Cameron et al., 2011). Thomson, Hirshberg, and Qiao (2011) also found a 9% increase in the number of arrest from a 3 month follow up to a 12 month follow up. Such results suggest a worsening of community adaptation over time. However, Nijhof and colleagues (2014) did not find police contacts to differ between youth post-RT and the general population. Though, youth discharged from RT were reported to be more likely to have limited social networks compared to the general population (Nijhof et al., 2014). Overall, outcomes related to community adaptation vary but do suggest that some youth may be struggling after RT.
**Family life.** Similar trends are seen regarding youth in their home environments post-RT. Preyde et al. (2011a) reported improved functioning within the home from admission to discharge ($t=10.02, p<.0001$). Less conflict arose in the family as a result of the youth’s mental health problems; however, family conflict was still common. Nonetheless, youth reported hopes to improve their family relations after discharge (Preyde et al., 2011a). Kapp and colleagues (2015) found parent hopefulness to significantly increase from admission to time of discharge ($t=22.76; p<.001$). Parent hopefulness related to satisfaction in the parent-child relationship, how capable parents felt to deal with their children, as well as how stressed and optimistic they were about their child’s future (Kapp et al., 2015). Youth entering RT may have emotionally or physically unavailable parents (Preyde et al., 2011a). However, the involvement of family during RT and post-RT has been associated with better long-term adaptation for those youth who can experience family involvement (Nickerson, Colby, Brooks, Rickert, & Salamone, 2007; Thomson et al., 2011). As previously discussed, many risk factors for EBD pertain to family functioning (Holmes et al., 2001); therefore, it may be difficult to involve these families in treatment. It may be that adequate family functioning is what enables some families to be involved in the youth’s treatment. Youth accessing RT from dysfunctional families may not be able to experience family involvement.

**School life.** School appears to be a life domain where high-risk youth are struggling post-RT. Frensch, Cameron, and Preyde (2009) examined school functioning in youth who accessed RT. These youth often have difficulty with regular school environments. At a 12 to 18 month follow up, 50% of youth leaving RT were not enrolled in school at a time when students could quit school at 16 years of age (Frensch et al., 2009). Greater delinquent behaviour at discharge related to poor school performance and attendance at follow up. Many youth leaving RT were
struggling with their schooling, with only a small group successfully completing their schooling (Frensch et al., 2009). However, Nijhof and colleagues (2014) did not find a difference in school attendance between youth discharged from RT and the general population. In another study, it was found that a majority of youth were enrolled in school at a 6 to 21 month follow up (Larzelere et al., 2001). However, current school failure rates may change as the legal age to quit school is 18 years of age in some areas (Ministry of Education Ontario, 2007). Outcome studies on school functioning are fairly variant.

**Overall outcomes.** Generally, different youth experience different outcomes after RT. Varying outcomes between youth after RT could be due the particular samples, treatment centres and the idiosyncrasy of mental health disorders. Outcomes after RT can vary based on the youth’s previous life experiences, such as the presence of parental abandonment or sexual abuse (Stage, 1998). Despite these inconsistencies, youth appear to be struggling in various life domains after discharge from RT. There seem to be some improvements in psychosocial functioning and symptom severity which may be maintained in the long-term for some youth (Preyde et al., 2011c); however, youth still appeared to be functioning with clinically significant impairment. While there is variation, many youth do not seem adapted to the community or school in the long-term after RT (Preyde et al., 2016). These struggles could be due to a variety of reasons, as each youth has different pre- and post-RT experiences. However, these struggles may reflect a youth’s difficulty coping and adapting to a new environment upon discharge.
Coping and Adaptation

*Coping.* The ability to cope with the environment not only permits one to survive, but allows one to thrive. While experiences during RT may be less variable due to its secured nature, the post-RT environment can be variable between youth. The present study was focused solely on youth who lived with their biological family after RT. Upon moving back with their family, the youth may face normative and idiosyncratic changes. This change in environment could make this population vulnerable to negative outcomes if they are unable to effectively cope – a vital component of mental health (Folkman, 1984).

For the current research, coping was regarded as part of the adaptation process and referred to the particular efforts individuals use to adapt to the environment (Compas et al., 2001; Folkman, 1984). Folkman (1984) defined coping as one’s continuous efforts to reduce or meet the demands arising from stressful circumstances. In this regard, coping is considered more a process than an outcome. The coping process functions to regulate emotions (emotion-focused coping) or deal with the stressor (problem-focused coping) (Folkman, 1984). Active coping strategies are focused on alteration of the stressor; passive coping strategies are not specifically focused on alteration of the stressor but may be focused on perceptions or emotions related to the stressor (Barendregt, Van der Laan, Bongers & Van Neiwenhuizen, 2015). Active coping may be referred to as problem-focused coping, while passive coping may be referred to as emotion-focused coping (Smith & Carlson, 1997). For example, youth may feel uncomfortable in their family home post-RT, which could elicit feelings of anxiety or sadness. Depending on youth coping style, they may choose to deal with their feelings of anxiety (emotion-focus) or they may analyze the environment to find what makes them uncomfortable (problem-focus). Commonly
cited coping strategies include problem-solving, information-seeking, escape/avoidance, support-seeking, social isolation, helplessness, and self-reliance (Skinner & Zimmer-Gemback, 2007).

The use of certain coping strategies may depend upon the individual. Appraisal of the stressor has been cited as an influencing factor (Lazarus & Folkman, 1984; Smith & Carlson, 1997). During appraisal of a stressor, an individual determines how to deal with the stressor (Lazarus & Folkman, 1984). For instance, to employ a problem-focused coping strategy, individuals should feel that their efforts can change the stressor (Smith & Carlson, 1997). In other words, the stressor should be malleable. Other factors pertain to available resources or the feasibility of coping strategies. In order to seek social support, one must have good social skills and relationships (Smith & Carlson, 1997). Holhahan and Moos (1987) examined personal factors related to coping. Family support was shown to positively correlate with the use of active-behavioural coping in a community sample (r=.17, p<.01) and in a clinically depressed sample (r=.26, p<.01). Conversely, greater family support was negatively associated with the use of avoidant coping in a community sample (r=-.34, p<.01) and in a clinically depressed sample (r=-.22, p<.01; Holahan & Moos, 1987). Therefore, in understanding one’s repertoire of coping skills, it is crucial to consider the available resources and the feasibility of a coping strategy.

Skinner and Zimmer-Gemback (2007) noted socialization and developmental processes as contributors to the development of one’s coping skillset. Parents influence the stressors children face and the resources children have to cope. Furthermore, natural development can influence one’s ability to use cognitive resources (Skinner & Zimmer-Gemback, 2007). Frydenberg and Lewis (1987) reported that adolescent girls used social support as a coping strategy more than adolescent boys (F=34.7, p<.0001). Other personality characteristics may
play a role. In a study with young adults, Schier, Weintraub, and Carver (1986) found that optimism positively correlated with problem-focused coping under controllable situations \( (r = .22, p < .01) \) and acceptance coping under uncontrollable situations \( (r = .33, p < .001) \). Although not statistically significant, pessimism appeared related to the use of denial and distancing from the stressor (Scheier et al., 1986). Coping skills can also be trained as part of therapy or intervention. A common coping strategy taught to youth with EBD is cognitive restructuring, which is focused on changing negative thoughts into positive thoughts (Schleider, Abel, & Weisz, 2014).

Different coping strategies are effective for different youth, especially in the realm of mental health, as each case is idiosyncratic. Lazarus and Folkman (1984) suggested a person-situation dependent view of coping processes. In this regard, coping processes are efforts used to deal with a stressor that depends on the person and the situation. The situation includes the illness as well as one’s psychosocial context, which includes one’s circumstances such as support, social norms and socio-economic factors (Shaw, 1999). Determining the effectiveness of a coping strategy may depend on how well the strategy fits the stressor. Additionally, coping can be assessed by how well the strategy fits the specific individual in a specific situation. For example, a problem-focused approach can be ineffective in a situation where there is no solution. It is difficult to assess the effectiveness of a coping strategy because coping processes are so highly dependent on the person (Lazarus & Folkman, 1984). The success of coping strategies could depend on how stressful the individual perceives the problem to be after attempts to cope (Folkman et al., 1986). For example, an individual may believe there has been improvement, no change or worsening of the stressor. Additionally, it is evident that problem-focused coping and emotion-focused coping can each foster positive or negative outcomes. Creating a plan to cope
with the stressor (problem-focused coping) and re-evaluating the stressor in a positive manner (emotion-focused coping) have been associated with improvements in stressor outcomes (Folkman et al., 1986). Conversely, holding a confrontational attitude towards the stressor (problem-focused coping) and being avoidant of the stressor (emotion-focused coping) have been associated with worsening of the stressor (Folkman et al., 1986). These findings are relational; the mere use of any specific coping strategy does not necessarily cause a specific outcome. Findings also vary between individuals, such that an effective coping strategy for one may be ineffective for another. For example, denial has often been regarded as an ineffective strategy; however, denial may be effective for those individuals unable to cope with the stressor (Folkman et al., 1986). Coping processes are dynamic between the person and the situation which causes difficulty in determining the effectiveness of coping strategies.

**Adaptation.** Coping is highly related to adaptation. Coping efforts set forth by an individual are attempts to adapt to the environment which the individual perceives as stressful or experiences as distress (Compas et al., 2001). Hanna and Roy (2001) described adaptation processes under the Roy Adaptation Model (RAM). The RAM is based heavily on a desire for an individual to adapt as a person, in a family or in the community. The RAM is used to outline individual needs under four different adaptive modes: the physiological mode, the self-concept mode, the role function mode and the interdependence mode. An individual during the physiological mode adapts to meet physical needs. During the self-concept mode, an individual adapts for spiritual integrity or a sense of purpose. During the role function mode, an individual adapts to achieve social integration or further role development. Finally, an individual in the interdependence mode adapts to build affectional relationships and support systems. The RAM
provided a framework for understanding the ways in which an individual adapts to the environment (Hanna & Roy, 2001).

Lehti (2016) proposed the theory of psychological adaptive modes. If a typical stress response is not enough for an individual to deal with a stressor, an adaptive mode may be triggered. An adaptive mode is a frame of mind, often involuntary, used to deal with the perceived stressor. Adaptive modes are different from regular stress responses in that they are comprehensive and cannot be repressed. It is recognized that some adaptive modes may be functional, while others may be dysfunctional. For example, a stressor could elicit feelings of sadness (normal stress response), short-term subclinical depression (adaptive mode), major depression (prolonged adaptive mode) or dysthymia (chronic dysfunctional state). Adaptive modes may cause an influx of cognitions and emotions, called the adaptive struggle. Under this theory, an adaptive struggle is the transition phase. Adaptive skills, or coping skills, are used to combat the adaptive struggle in order to deal with the stressor. These coping skills may range from problem solving to using one’s social network. Determining the adaptiveness of a psychological reaction is based largely on whether the individual returns to homeostasis. If an individual adapts successfully, an adaptive mode is no longer needed. This theory provides a functional perspective on the adaptation process (Lehti, 2016).

Adaptation pertains to how individuals regulate their emotions, behaviours, cognitions and attempts to change the environment perceived as stressful or change their perceptions of the environment (Compas et al., 2001; Folkman, 1984). Smith and Lazarus (1990) highlighted the importance of emotion in adaptation. The role of adaptation is to promote behaviours which help individuals meet the demands of the biological and social environments. In order to successfully do so, an individual must recognize when adaptation is needed and produce behaviours to fulfil
the need. Adaptation may be regarded as an ongoing coping with the environment (Smith & Lazarus, 1990). Based on these ideas, adaptation in this paper was operationalized as an individual’s personal and psychological adjustment to environmental changes or an environment perceived as stressful. Other researchers have measured adaptation in a variety of ways, often measuring proxies of adaptation such as self-esteem, stress or emotional well-being (e.g. Taylor & Alpert, 1973; Thomson et al., 2011; Wells, Wyatt, Hobfoll, 1991). Such studies were based on the idea that if an individual is adapting well, then an individual may be free of morbidity and disorder. In comparison, the current research was focused on perceptions of adaptation.

Successful adaptation is based on how well efforts reduce or change the perceived stressors (Compas et al., 2001). Awareness of several problem-solving strategies can also help during the adaptation process (Rutter, 1985). Generally, the ability to adapt successfully is related to an individual’s self-esteem, self-efficacy and support networks (Rutter, 1985; Werner, 1955). Displaying agency or having influence over one’s personal functioning and the environment has been noted to support adaptation (Bandura, 2006). The idea of competence relates to the resources and characteristics one needs to adapt successfully (Compas et al., 2001). Competence changes with the environment (Masten & Coatsworth, 1998); it is possible that youth leaving RT need to enhance their competency in order to successfully adapt from a highly-structured environment to their family home. Successful adaptation may be subjective; however, it is noted that some youth may be resilient in their ability to face hardship. Resilience is related to positive adaptation to adverse situations (Masten & Obradović, 2006). The development of resiliency and positive adaptation is largely based on good family relationships, especially parents (Wright & Masten, 2005). Having supportive and healthy parent-child relationships promotes secure attachment patterns. These types of parents would display effective responses to
stress and adversity, which the child would experience and learn (Wright & Masten, 2005). Characteristics of resilient adolescents include good intellectual functioning, high self-esteem, close parent relationships, prosocial adult bonds and effective schooling (Masten & Coatsworth, 1998). From understanding the risk factors (e.g. psychological and familial) of EBD, youth with EBD may not have such resilient characteristics. However, the ability to adapt and be resilient to adversity can be fostered through community, family, and school initiatives focused on resiliency (Khanlou & Wray, 2014).

The Transition after Residential Treatment

The need to understand transitioning home. Transitioning to a new environment can be difficult. Leaving RT and returning to a family home may be a challenging transition for youth. Youth who simultaneously experience change across multiple life domains are at greater risk for negative outcomes, such as lower self-esteem or lower grades in school (Simmons, Burgeson, Carlton-Ford, & Blyth, 1987). The change in residence may prompt changes in a variety of domains; youth must adjust to all these changes while coping with EBD symptoms. This transition also means youth leave a highly secure setting and often go to a less secure setting. Some youth may have difficulty adapting to their new environments. Youth may need to effectively cope in order to adjust to this change in residence. In the current study, transitioning is related to psychological adaptation and does not necessarily pertain to EBD symptoms. However, if youth do not transition well after RT, symptoms may worsen.

It is important to understand why transitioning home from RT can be challenging. Leichtman and Leichtman (2001) highlighted reasons why youth may lose gains made after
discharge from RT. First, the nature of mental health disorder should be considered. Many mental health disorders are long-term and chronic conditions. Youth who access RT struggle with serious mental health problems, which may hinder successful transition after RT. Poor transitioning could be due to lack of treatment after discharge from RT. Youth may need to access other community-based mental health services and a continuity of care to cope with their conditions. Preparation for transitioning back into the community may not be provided adequately during RT. Another reason for poor transitioning might be that youth return to the same family environment which contributed to the onset of their mental health problems, as the examples previously discussed (Leichtman & Leichtman, 2001). Hence, understanding youth leaving RT to return to a family home is critical. It is suggested that RT should incorporate transition planning in order to mitigate these effects (Leichtman & Leichtman, 2001).

Few studies have been focused on youth returning to their family homes (Lyons et al., 2009). However, Pumariega (2007) outlined why youth in RT need to be transitioned back into their families effectively. Youth leaving RT and returning to a family may need to re-establish their roles again. These roles may even be absent, which can alienate youth in their own homes. In this regard, it is suggested that youth should be discharged from RT as soon as possible. Caring for a child with a chronic condition is demanding; it is common for families to believe it is the child who needs to change when they are admitted to RT. However, Pumariega (2007) underscored the need for families to adjust to the needs of the child, especially upon their return home. Further, families should continue to seek community services to further support their children. The successful transition of youth leaving RT into their homes is undoubtedly dependent on the family as a system. Families as a whole should assume responsibility for the
recovery and transition of youth leaving RT (Pumariega, 2007). Therefore, research on youth transition post-RT should reflect this understanding and try to incorporate the family perspective.

**Transition studies.** Early researchers, Taylor and Alpert (1973), acknowledged the importance of understanding the adaptation period youth face after RT. However, there has been minimal movement in the literature on this topic since then. Few studies have been conducted on the transition youth face after RT and even fewer studies have been focused on short-term adaptation or the immediate transition period. However, the initial transition period after mental health treatment may be difficult. For example, clients leaving RT for substance abuse will often experience relapse during the first month (Gossop, Stewart, Browne, & Marsden, 2002). Although this study was conducted about 10 years ago and in a different system, it is important because a few youth who access RT may also have problems with substance abuse (Preyde et al., 2016). While this finding pertains to a different sample and type of RT, it highlights the importance of successful transitioning, especially during the initial period. Therefore, it is important to how understand how youth transition home after RT initially and long-term.

There has been some inquiry regarding how RT helps youth transition home. Nickerson and colleagues (2007) examined whether RT prepared youth to transition after discharge, based on the perspectives of 21 staff, 17 mothers, 4 fathers and 20 youth (17 male and 4 female) prior to discharge. Interviews with staff showed that transition planning did take place, approximately 6 months into treatment. These plans included a multidisciplinary team meeting and preparing family members for the transition. Staff reported teaching youth skills needed for the transition, working directly with families, helping youth be involved in community activities and providing resources youth may seek in the community. Parents and youth agreed with all these reports and most parents found them helpful. However, there was still room for improvement. Parents
requested more parent education and training on how to deal with their children upon return. Youth requested more home visits during RT. Interestingly, these three perspectives were more divided on the concerns for youth post-RT. Staff had the most concerns regarding how well the youth would transition into the family, community, peer circle, school and ultimately having to return to RT. Parents expressed concerns on how well the youth will transition into the family and school. Finally, youth were mainly concerned with how they will get along with family.

Data were collected during RT; therefore, the transition period is not reflected. However, these results provide a framework for understanding the opinions of youth and parents on the forthcoming transition home. Evidently, transitioning into the family is the most common concern – warranting scientific inquiry (Nickerson et al., 2007).

Examining the long-term adaptation of youth after RT is important to understand the future outcomes of these youth. Wells and colleagues (1991) studied factors associated with adaptation of youth who have been discharged from RT for 12 to 36 months. Adaptation was defined using seven variables: high self-esteem, a sense of mastery, absence of psychopathology, involvement in school or work, non-involvement in antisocial behaviour, absence of substance use and non-use of restrictive psychiatric services post-RT. Data were collected from 50 youth (29 male and 21 female); the opinions of parent or mental health professionals were not included. Generally, it was found that greater family support, reduced stress and sound stability correlated with adaptation at follow up. Greater family support was predictive of higher self-esteem (β=.34), higher mastery (β=.36) and lower psychopathology (β=−.38, ps<.01). Greater amounts of stress predicted greater use of restrictive services (β=.37, p<.01). Finally, greater residential stability predicted less antisocial behaviour and less substance use (β=−.37 and β=−.41, ps<.01, respectively). Such results gave insight into factors that can help youth adapt well after
RT. However, adaptation was defined as a set of variables based on treatment goals, government policy and common societal standards (Wells et al., 1991) and the authors did not operationally define adaptation. The focus seemed to be on outcomes associated with adaptation rather than the adaptation experience. It is possible that at 12 months post-discharge, there is a different adjustment required compared to 36 months post-discharge. Further, the adaptation variables were measured using questionnaires or Likert scales. These quantitative measures allowed for a variety of multivariate analyses, but the lived experiences of these youth were not captured. The results of Wells et al. (1991) demonstrated what factors related to youth adaptation in the long-term, based on the narrow definition of adaptation used. Therefore, there is scant information on the adaptation experience and the perspective of family members.

Only two studies relevant to the experiences youth face after RT were located. First, a study by Hess, Bjorklund, Preece, and Mulitalo (2012) was focused on the transition experiences of parents and youth. The purpose of the study was to understand the immediate challenges of youth who have successfully transitioned home. The study was intended to inform other youth and their families of factors that can aid in the transition process. Qualitative phone interviews were conducted with 14 fathers, 13 mothers and 11 daughters who were classified as successfully transitioned. The researchers stated that data from another 125 families were included, but information on these families was not provided. The participants were admitted into RT within a 4 year range (2004 to 2008). It was not stated when the data were collected, but it seems that the data were collected during a long-term transition period. It is also unclear how youth were classified as successfully transitioned. Interview questions included: (1) how was the transition process, (2) what was the hardest part of the transition for the family and (3) what kind of advice or tips would you give to a group of parents soon to experience transition. Data were
analyzed to determine themes common to both the parent and youth perspectives, as a comparison was not the goal of the study (Hess et al., 2012).

The families in Hess et al. (2012) commented that parents should have confidence and trust in their children. This trust can allow parents and their children to set realistic goals and structure within the family. Often highlighted was the need for parents and their children to understand that effective transitioning will require continuous efforts from the family and that setbacks were inevitable. Finally, parents must show eagerness to change personally (Hess et al., 2012). These findings indicated what youth can expect when transitioning home and what parents can do to help the transition. It is an advantage that both the parent and child perspective were included. However, the results were reported in a way that showed similarities in experience, neither experience was explored in depth individually. Lastly, the researchers stated an interest in the immediate transition period, but it was unclear how soon the data were collected after discharge. Therefore, these findings may not capture experiences during the immediate transition home. Additionally, this research was not focused on coping and adaptation; therefore, coping experiences were not shared. Nonetheless, the results of Hess et al. (2012) provided some insight into how youth and their parents experience this overall transition home.

In a second transition study, Thomson et al. (2011) examined the transition experiences of parents and youth after RT. The purpose was to understand the adaptation of adolescent girls after discharge from a particular RT centre. A number of variables were examined including social functioning, living situation, transition experiences, coping skills and aftercare services. Transition experiences and coping skills were of current interest. Qualitative interviews were conducted with 33 parents, 12 youth and 20 non-kin caregivers (i.e. case worker or foster parent)
at 3 months post-discharge. Qualitative interviews were also conducted with 37 parents, 6 youth and 10 non-kin caregivers at 12 months post-discharge. It was unclear as to why the sample varied between 3 and 12 months post-discharge. The gender of parents who participated was also not mentioned. The in-depth interviews seemed to capture qualitative comments and qualitative experiences, since it included close-ended and open-ended questions. Interview questions were related to five areas: level of care, education, hospitalizations, arrests or detentions, and aftercare services. While parts of the interview may include proxies for adaptation (i.e. hospitalizations or number of arrests), it is unclear how much interest was in the transition process. At 3 months post-discharge, some parents reported easy transitions for their children into the family and school. However, also at 3 months post-discharge, some youth revealed difficulty adjusting due to a lack of structure in the post-RT environment. One case worker shared that the youth with whom she worked struggled the most immediately after discharge, but over time the youth seemed to adapt and was functioning well. Conversely, the authors noted that some youth had the most difficulty at the 12 month follow up. For example, one mother said her daughter was doing well immediately after discharge but then returned to her previous negative behavioral patterns in the long-term. Similarly, quantitative data also showed poor community adaptation in the long-term. For example, more youth were arrested, hospitalized or not in school at a 12 month follow up, compared to a 3 month follow up. This finding suggested some difficulty adapting to the community long-term. However, some youth struggled more at a 3 month follow up, while other youth struggled more at a 12 month follow up. Evidently, there was variation in youth functioning but the results of Thomson et al. (2011) suggested that youth struggled to transition after RT.
Thomson et al. (2011) provided some insight into youth coping experiences after discharge. Youth reported using coping skills learned in RT. For example, writing and listening to music seemed helpful for youth. The authors also noted that the use of dialectal behavioural therapy (DBT) was helpful after RT. It was not stated whether these coping skills were reported at 3 or 12 months post-discharge; irrespective, it is not known how youth cope in the immediate post-discharge period. Additionally, the study focused on one RT centre; the generalizability of the results is unknown. Youth under custody of the government were also included in the sample (Thomson et al., 2011), which could influence results or explain some of the variability. Generally, youth did not appear to adapt well into the community or school in the long-term; for example, greater instances of community misconduct occurred 12 months after RT compared to 3 months after RT (Thomson et al., 2011). This research contributed to the general understanding of transition experiences youth face at 3 and 12 months post-RT. However, coping and adaptation experiences were not explored in depth, as it was not the central focus of the study. It is unknown why some youth experienced the transition differently from others. Further, the immediate discharge period was not studied, such as the first few weeks home.

**Study Rationale**

Understanding the post-RT transition is important. Outcomes related to adaptation have been studied. It is known that family involvement during RT and family support post-RT are associated with the adaptation of youth (Taylor & Alpert, 1973; Wells et al., 1991). However, thus far, the emphasis seems to be on long-term adaptation rather than short-term adaptation. It is also established that youth struggle to transition home post-RT for many reasons including the nature of their condition and lack of support (Leichtman & Leichtman, 2001). Youth may return
to a family environment where their roles are displaced (Pumariega, 2007), but it is not known
how youth cope with these experiences. Hess et al. (2012) studied the transition of youth
returning home, but the focus was on youth who had successfully transitioned home in order to
inform future policy and planning. Thus, from Hess et al. (2012), little can be said about youth
who did not transition well. Research by Thomson et al. (2011) showed variation in the transition
experiences of youth at a 3 and 12 month follow up. Additional research is needed to understand
these variations and the immediate transition experiences after RT (around 1 month). Overall,
there seems to be scant research on: (1) youth and parent experiences during the immediate
transition period (2) how youth cope with these transition experiences.

The perceptions and attitudes of parents have been shown to influence the treatment
children receive for their mental health disorders (Richardson, 2001). Youth with EBD may not
have accurate perceptions of their emotional adjustment (McCauley Ohannessian, Lerner,
Lerner, & von Eye, 1995) or have limited insight on their problem behaviour (Nijhof et al.,
2014). Since the current research was focused on the initial transition period, it is likely that
youth were struggling with their symptoms. Therefore, exploration of youth coping and
transition through their parents’ perspective is a rational choice. Parents seem to understand the
struggle their children have as they transition home. One parent in Hess et al. (2012) said “it’s
one thing for them to do well in a very structured, controlled environment; it’s a much different
thing to do well in a much different environment” (p. 156). Parents can also give detailed
descriptions of their child’s wellbeing (Sixsmith, Nic Gabhainn, Fleming, & O’Higgins, 2007).
There is minimal research on how youth manage and cope during the initial transition home from
RT from any given perspective. It is acknowledged that the youth perspective would also have
important contributions.
The preliminary purpose of this study was to explore parent reports on the initial transition experiences when their child returned home from RT. The main purpose of this study was to explore parent reports on how youth cope and manage with the transition after RT. The preliminary purpose was necessary to understand the experiences which co-occur with the transition. Thus, how youth cope with the change in residence and the associated transition experiences was explored. Since this is a relatively new topic in the literature, an exploratory phenomenological design was used. Groenewald (2014) explained that the philosophical underpinnings of this methodology emphasize the need to study experience in order to understand a phenomenon from a certain perspective. Those who have experiences with the given phenomenon may understand the realities of it. A person can portray how an experienced phenomenon displays itself and what it means to their consciousness (Groenewald, 2014). The current research is focused on the experiences of parents after RT. Thus, a phenomenological approach can provide a framework to elucidate these experiences. Additionally, a phenomenological approach can allow the researcher to understand common or shared experiences between individuals (Creswell, 1998). Questions during an in-depth parent interview were open ended to allow exploration of this topic. In-depth interviews helped capture the experiences and perceptions of parents. Although this study was exploratory in nature, it was hoped that the findings can foster understanding of transition experiences and coping strategies used by youth. This understanding may have practical implications and inform transition planning.
Methods

This study was conducted as part of an ongoing longitudinal project that received institutional ethics clearance from the University of Guelph and Wilfrid Laurier University (see Appendix A) and is focused on psychosocial outcomes of youth who have received RT. The current study was a primary analysis of existing data and was the first report of parents’ experiences with the return of their child.

Participants

Participants in the overall project were recruited from seven mental health agencies in south-western Ontario serving youth aged 12 to 18 years. The inclusion criteria for the overall project were youth and parents/caregivers of youth who received RT for EBD symptoms. Youth had to be able to communicate in English and provide consent (e.g. developmental disability may hinder the ability to provide consent). The inclusion criteria for this analysis were biological parents of youth aged 12 to 18 years with moderate to severe EBD who were discharged from RT. The intended discharge of the youth had to be into the care of their family.

This study was a primary analysis of existing data as part of an ongoing longitudinal project. At the time of data analysis, an insufficient number of fathers participated in the study needed to explore fathers’ experiences. In order to meet a recommended sample size of 10 (Creswell, 1998; Guest, Bunce, & Johnson, 2006; Polkinghorne, 1989) and maintain homogeneity among the sample (Sandelowski, 1995; Youniss & Ketterlinus, 1987), ten interviews with mothers were used. Hereafter, participants will be referred to as mothers.
Procedure

Youth and their families were made aware of the study by staff at the mental health agencies. If the youth was below the age of 16, staff contacted the mother for permission to release contact information to the researchers. If the youth was 16 years old or older, staff asked the youth directly for permission to release contact information to the researchers. If permission was granted, staff provided the contact information of youth and their families to the researchers. The researcher then contacted the families by phone to fully describe the study and request consent. For families who provided informed consent, the researcher scheduled an interview time and location. Mothers received $40 compensation for their participation.

An in-depth, semi-structured interview was conducted in person with individual mothers approximately 4 weeks after the youth’s discharge from RT. Interviews were conducted by four trained graduate students (including myself) and professors. The author of this report conducted one interview in this sample. Aside from the author of this report, the interviewers did not analyze the data for this study. Four weeks was chosen because it was close enough to discharge to be considered an immediate post-discharge period, but gave the youth time to experience some transition home. Interviewing during the immediate transition period, rather than later, may have helped participants retrieve episodic memories (Anderson, 1983). Prior to the start of the interview, written consent was obtained (see Appendix B) and participants were reminded that the interview was audio recorded.
Interview Protocol

An interview guide was used to capture demographic information and mothers’ lived experiences. Demographic and background information regarding the mothers included: age, number of children in home, marital status, visible minority status, aboriginal status, employment status and frequency of contact with child. Field notes were also taken by the interviewer.

Interview protocol consisted of open-ended questions on youth and mothers’ transition experiences during the initial transition home from RT. The interview guide had three general sections: transition experiences, domains of life and personal functioning (interview protocol can be seen in Appendix C). Questions were asked about the following domains of life: school, work, family life, peers, community, and hopes and dreams. Questions about personal functioning were asked for each domain of life (e.g. what does the youth do when things do not go well at home); however, more specific questions about emotional well-being were also asked separately (see Appendix C).

Prompts were used to promote elaboration on the topic. Probes were used if the researcher needed clarification on a comment. The interview protocol was used to guide the interview; however, mothers were encouraged to talk openly about the youth’s personal functioning during this initial transition. Prior to the start of the interview, the interviewer informed the mother that they were going to ask questions about how the youth was doing since discharge. Mothers were informed there were no right or wrong answers and specific questions may be asked to know how the youth was doing emotionally. Interview questions were guided by previous research and some understanding of theories of adaptation. Interviews were approximately one and a half to two hours in length. The interviews were audio recorded and the interviewer took analytic notes during the interview.
Measures

Mothers completed the parent version of the strengths and difficulties questionnaire (SDQ) to provide insight into youths’ psychological difficulties (Goodman, 1999). The SDQ is composed of 25 questions equally distributed among five subscales: emotional problems, conduct problems, hyperactivity-inattention, peer problems and prosocial behaviour (Goodman, 1999). Each question is rated on a 3-point scale; subscale scores can range from 0 to 10. Higher scores indicate greater difficulties except for prosocial behaviour where higher scores suggest greater prosocial behaviour. The total difficulties score is the sum of subscale scores (excluding prosocial behaviour) and can range from 0 to 40 (Goodman, 1999). Scores for each subscale and total difficulties can be categorized as close to average, slightly raised, high or very high (See Appendix D; Goodman, 1997). The SDQ has demonstrated low to moderate internal consistency for each subscale: emotional problems (α=0.67), conduct problems (α=0.63), hyperactivity-inattention (α=0.77), peer problems (α=0.57) and prosocial behaviours (α=0.65). However, the total difficulties scores appear highly reliable (α=0.82). The parent SDQ has also been shown to correlate with other measures of clinical symptoms, have fairly good construct validity and good inter-rater correlations (Becker, Woerner, Hasselhorn, Banaschewski, & Rothenberger, 2004; Goodman, 1998; Stone, Otten, Engels, Vermulst, & Janssens, 2010).

Setting

Once the researcher made contact with the participant, an interview date was set. The interviews took place in a location of the participant’s choosing, which was often the home of the participant. For confidentiality, the researcher ensured that the youth and other family members were not nearby. An audio recorder was placed between the researcher and the mother, to which
the mother would need to consent. Depending on the home, the researcher sat adjacent to the mother, often in the living room or kitchen of the home. The interviewer was encouraged to maintain an open, non-judgemental and receptive attitude toward the mother.

**Data Analysis and Sample Size**

Creswell (1998) described how phenomenology is focused on understanding the “essence” of a phenomenon. This “essence” can be interpreted from common or shared experiences among those who have experienced the phenomena. Researchers collect detailed experiences of individuals who all experienced the same phenomena. Disregarding personal biases to the extent possible, the researchers extracted common experiences to establish this “essence” (Creswell, 1998). As previously discussed, minimal scientific inquiry has been conducted on the current topic. A phenomenological approach allowed for exploration of how mothers believed their children experienced the initial transition. In order to gain richness of detail and understanding, a phenomenological approach suggested exploring the experiences of 6 to 25 individuals. A general guideline to reach saturation is to include 10 transcripts; therefore, the current research was based on 10 mothers (Creswell, 1998; Guest et al., 2006; Polkinghorne, 1989). Saturation in the current sample was reached at the end of the eighth transcript.

Interviews were transcribed verbatim by three undergraduate research assistants in Microsoft Word. These transcribers did not conduct any interviews or analyze the data. Interview transcripts were then uploaded into NVivo, a tool which allows qualitative researchers to store and manage data. Interview data were analyzed by myself and a trained doctoral student experienced with qualitative data analysis. Interview data were analyzed using thematic content analysis as described by Braun and Clarke (2006; reference to be updated). Thematic content
Thematic analysis fits into the phenomenological approach in that it helps to identify the “essence” behind data. Thematic analysis is a comparative process; various interview data were compared for identification of common patterns and similarities (Green & Thorogood, 2013). The researchers analyzed the data for content related to the research question. Similar and relevant content with the data were grouped into “themes”. A theme “captures something important about the data in relation to the research question and represented some level of patterned response or meaning within the data set” (p. 10). Determination of the themes was at the discretion of the researchers. Themes can be based on what is prevalent in the data and what answers the research question saliently (Braun & Clarke, 2006). However, unique or contrasting information can also be reported. For instance, if a piece of information seemed important to how mothers believed their child adapted to the home environment after RT, then it may be reported as a finding.

Thematic analysis is flexible, as it can be catered to the specific purpose of a study. An exploratory study can be focused on common experiences or issues, rather than attempting to understand the relationships among themes (Green & Thorogood, 2013). Since there are few studies on the current topic, an inductive approach to analyzing the data was used (Braun and Clarke, 2006). An inductive approach means thematically analyzing the contents of the data to determine themes. This approach is data-driven. Identified themes were strongly linked to the data; personal biases and preconceptions were minimized. The researchers kept the research question in mind during analysis. In this regard, themes were identified from the data but were coded based on the research question. Further, themes were coded at a semantic level of analysis. For this level of analysis, the investigators aimed to describe the explicit or surface meaning in the data. Again, this was suited for the novelty of this topic (Braun & Clarke, 2006).
To begin the data analysis, the researchers first read the transcript as a whole to familiarize themselves with the content. Field notes provided by the interviewer were also reviewed to give contextual understanding, as only one interview was conducted by one of the data analysts. During the first read of the transcript, information that seemed relevant to the research question was highlighted. Initial codes and themes were labelled within the text of the data in NVivo to keep track of the researchers’ thoughts and ideas. During subsequent reads of the transcript, the researchers focused on the applicability of the initial codes and added more codes that may have been missed during the first read. This process was conducted for the first three interview transcripts. After the first three interview transcripts were coded, both data analysts met to ensure similarity in findings and discuss any discrepancies in opinion. Minimal discrepancies were found between the two set of codes and themes. Discrepancies were often because the researchers labelled similar codes and themes with different names (e.g. awkwardness and strange feeling). In this case, the researchers decided which label was most appropriate for that code or theme and used that label in subsequent analyses. Other discrepancies occurred because interesting themes were highlighted that were unrelated to the research question. In this case, the researchers discussed the relevancy of this information and decided whether to discard it. After this initial meeting, another set of three interview transcripts were coded using the same procedure. After six transcripts were coded, the data analysts met again to discuss larger themes and relationships in the data. For example, the analysts found that some initial themes were similar and could be combined into one theme. Subthemes were also determined at this time which helped develop a larger theoretical framework. The analysts elaborated on the themes and provided examples, which were kept in a codebook. Any discrepancies between results were resolved prior to coding other transcripts. The remaining four
transcripts were coded using the same process as before; however, the codebook was applied during analysis of each subsequent transcript. After all transcripts were coded, the data analysts met to determine the final themes and subthemes.

Many procedures were employed to enhance trustworthiness (Creswell, 1998; Creswell & Miller, 2000; Golfshani, 2003). The data were analyzed independently by two different graduate students (myself and a doctoral student) knowledgeable about the current topic to enhance the credibility of findings. Any differences between both analyses were noted and resolved through discussion. For the same purpose of credibility, peer debriefing was done with a different researcher (MP) who was knowledgeable of the current topic and did not conduct interviews, transcribe interviews or analyze the data. The researchers also conducted a negative case analysis and reported any data opposing the conclusions originally drawn from the data to enhance trustworthiness. Finally, member checking was done by sending a short description of findings to participants for feedback (see Appendix E). This description included short descriptions of important themes. The same description was sent to all participants; therefore, it was noted that some of the themes may be from other interviews. Participants were asked whether the themes represented what they shared in their interview (Creswell, 1998; Creswell & Miller, 2000; Golfshani, 2003).

Quantitative data (demographics and SDQ) were entered into the statistical package for social sciences (SPSS). Demographic information and SDQ scores were analyzed using descriptive and frequency statistics. SDQ scores were analyzed using frequency statistics to categorize each score in the 4-band categorization (see Appendix D).
Results

Sample Characteristics

Among the ten mothers selected for this analysis, the discharge was not entirely in the home of the mother for two cases. In one case, the youth was first discharged into the care of the father and resided at his house, and then the youth transferred into the care of the mother. In a second case, the youth was discharged into the care of the mother but went directly to a group home and went home on weekends. It should also be noted that another youth was in the care of CAS during RT and returned to the mother’s care after discharge, and another youth was in the care of CAS before RT, was discharged from RT into the care of the mother and subsequently became a ward of CAS.

Demographic and background information of the mothers appear in Table 1. The average age of mothers was 45.2 years ($SD=6.4$) with a skewness of -0.12. The age of mothers was normally distributed and ranged from 35 to 55 years. The average number of children in the home was 2 ($SD=0.9$) with a skewness of 0.99. The number of children in the home also appeared normally distributed and ranged from 1 to 4 children. Five mothers were married or in common-law relationships; five mothers were divorced, separated or single. Majority of mothers (n=9) did not identify as a visible minority and a couple of mothers (n=2) reported aboriginal status. Most mothers (n=7) were employed, but a few (n=3) were unemployed. Eight mothers provided their salary range which appear in Table 1. Two unemployed mothers were receiving disability support benefits from the government. Lastly, the mothers reported seeing their child daily (n=10) after discharge.
Table 1

*Mother Demographics and Background Information*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Variable Subcategory</th>
<th>n</th>
<th>%</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td>45.2 (6.4)</td>
</tr>
<tr>
<td>Number of Children in Home</td>
<td></td>
<td>2</td>
<td>0.9</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td>Married</td>
<td>3</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Common-law</td>
<td>2</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Divorced</td>
<td>3</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Separated</td>
<td>1</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Single</td>
<td>1</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Visible Minority</td>
<td>Yes</td>
<td>1</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>9</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Aboriginal Status</td>
<td>Yes</td>
<td>2</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>8</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>Employment Status</td>
<td>Employed</td>
<td>7</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unemployed</td>
<td>3</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Salary Range(^a)</td>
<td>0–29,999</td>
<td>2</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td></td>
<td>30,000–59,999</td>
<td>2</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td></td>
<td>60,000–89,999</td>
<td>2</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td></td>
<td>90,000+</td>
<td>2</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Frequency of Contact with Child</td>
<td>Daily</td>
<td>10</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

*Note.* \(^a\)Based on a sample size of 8.
The demographic and background information of children appear in Table 2. The average age of children was 15.6 years ($SD=1.4$) with a skewness of 0.24. The age of children appeared normally distributed and ranged from 14 to 18 years. These mothers represented a group of children with an approximately even split in gender: 4 children were male and 6 children were female. A majority of children were neither a visible minority or of aboriginal descent. Table 2 also provides the average scores for each subscale of the parent version of the SDQ. Table 3 provides a breakdown of scores based on the 4-band categorization (Goodman, 1997). In reference to Table 3, 60% of children were categorized with a high degree or very high degree of difficulty for emotional problems, conduct problems and peer problems. Additionally, 80% of children scored high or very high on total difficulties by their mothers.

### Table 2

**Youth Demographics and Psychological Difficulties**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Variable Subcategory</th>
<th>n</th>
<th>%</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td>15.6 (1.4)</td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
<td>4</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>6</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Visible Minority</td>
<td>Yes</td>
<td>2</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not Sure</td>
<td>2</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>6</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Aboriginal Status</td>
<td>Yes</td>
<td>1</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>9</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>SDQ</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------</td>
<td>---------------</td>
<td>---------------</td>
<td>---------------</td>
</tr>
<tr>
<td></td>
<td>Emotional Problems</td>
<td>5.3 (2.3)**</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conduct Problems</td>
<td>3.3 (2.3)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hyperactivity-Inattention</td>
<td>6.1 (1.4)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Peer Problems</td>
<td>3.8 (1.9)**</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prosocial Behaviours</td>
<td>8.6 (1.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total Difficulties</td>
<td>18.5 (4.8)**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* *slightly problematic; **highly problematic.

Table 3

Frequency of Youth Within 4 Categories of Psychological Strength and Difficulty (n=10)

<table>
<thead>
<tr>
<th></th>
<th>Close to Average</th>
<th>Slightly Raised</th>
<th>High</th>
<th>Very High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Problems</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Conduct Problems</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Hyperactivity-inattention</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Peer Problems</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Prosocial Behaviours</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Difficulties</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>
The Transition Period

The preliminary purpose of this study was to explore mothers’ reports on the transition. Mothers corroborated the presence of a transition period. Six themes were identified in the data: youth readiness, adjustment, mother readiness, re-establishment of social networks, the honeymoon period and change in environmental structure. These themes describe different aspects of the transition experience faced by mothers and youth. The definition of each theme and illustrative quotes can be seen in Table 4.

The most common theme regarding the transition period was youth readiness (n=9). Of the nine mothers, eight mothers felt their child was ready to return home and one mother did not feel her child was ready to return home. Some reasons why youth wanted to leave included: being tired of treatment, wanting to get away from other residents or completing the program. Conversely, one mother reported that her son was not ready to return home; however, the youth had aged out of the program and was forced to leave RT. It is unknown whether the mother’s opinion would change if the youth completed RT as scheduled.

Another prominent theme was the concept of adjustment. This theme provided contextual insight into the transition experience for the family. Many mothers (n=8) referred to strange feelings or awkwardness. These mothers felt their child experienced some adjustment and reported some adjustment required for themselves. If there were other family members in the home, this adjustment seemed to be within the larger, family context as well.

The theme of mother readiness was also noteworthy. Many mothers (n=7) commented on how ready they were for their child’s return. Five mothers felt that they were prepared for their child’s return; perceived readiness sometimes depended on their child’s behaviour upon return. On the other hand, two mothers clearly expressed some ambivalence regarding how ready they
were for their children’s return. This ambivalence can be seen in answers that are “yes and no” or “somewhat ready.” This ambivalence stemmed from feelings of instability or fear of the unknown.

The theme of re-establishment of social networks provided insight into one transitional challenge youth faced. Some mothers (n=4) mentioned a need for their child to rebuild social connections. Mothers reported that youth needed to make new friends or reconnect with old friends during the transition. Some youth appeared to miss former relationships at RT with staff or other residents. Other youth had difficulty reconnecting with old friends because they were absent for a while or were struggling with a fear of stigma.

<table>
<thead>
<tr>
<th>Table 4</th>
<th>Themes Related to the Transition Period (n=10)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme (%) and Definition</strong></td>
<td><strong>Quotes</strong></td>
</tr>
<tr>
<td><strong>Youth Readiness (90%)</strong></td>
<td>“She actually did say that the reason she wanted to come home was to get out of the group home and away from the kids because they drove her crazy.” (Ready)</td>
</tr>
<tr>
<td>Youth readiness is how prepared or willing youth were to return home from RT.</td>
<td>“It got to the point where she didn’t want to be there anymore.” (Ready)</td>
</tr>
<tr>
<td></td>
<td>“This isn’t something you can just learn in 6 months and he certainly couldn’t come home without any support.” (Not ready)</td>
</tr>
<tr>
<td><strong>Adjustment (80%)</strong></td>
<td>“It’s awkward, I mean there’s a lot of things that are different here.”</td>
</tr>
<tr>
<td>Adjustment refers to a need to change to meet the requirements of a new environment. This adjustment may coincide with feelings of awkwardness.</td>
<td>“I think it’s more of that transition time for her and always assuring her that it’s not just you know, you’ve hit the end and that’s it.”</td>
</tr>
<tr>
<td></td>
<td>“We’re making it work. Again, there’s still a lot of stretching and juggling going on to make up for where we’ve been but...”</td>
</tr>
</tbody>
</table>
uh we’re doing our part. We’re all cleaning and doing out bits to help and trying to support each other.”

**Mother Readiness (70%)**

Mother readiness is how prepared mothers felt to have their child return home from RT.

“Yeah, we were more than ready.” (Ready)

“Me? I’m ready as long as she went to school.” (Ready)

“I think so, I mean it’s always scary... I’m still nervous, I mean I have a lot of work to do and it’s not perfect.” (Somewhat ready)

“Um, yes and no. Um, yes I was ready in the sense that, you know, his bedroom was all ready and the house was ready. … but we were all a little bit scared.” (Somewhat ready)

**Re-establishment of Social Networks (40%)**

Re-establishment of social networks refers to a need to rebuild social networks after RT.

“I think it was just being away from [agency name]. Like, I had to remind my common-law husband and [youth’s] brother, that he was there for a long time. He was there for almost 10 months and he formed bonds with the people there and it’s like losing family.”

“So any friends he had aren’t really close anymore. So I think he feels like he’s starting over that way.”

**The Honeymoon Period (40%)**

The honeymoon period is a term used to explain how common problems appear absent at first, but begin to resurface after some time.

“We were all excited to have him back... I was very very happy to have him back. And it’s like the honeymoon period too, so it was all good... The first few days were similar... very up-beat, he was so happy... pretty much stayed that way until the second week he was home. So that’s when things changed and you could tell he kind of missed [agency name].”

“That was really good in the beginning and I’d say in the last week he’s kind of fallen out of that.”
### Change in environmental structure (30%)

| Change in environmental structure refers to a reduction of environmental structure or a lack of routine in the post-RT environment. | “A little uncertain about being able to manage without that constant environment that she was in.” |
| “She’s been struggling with that a lot, that kind of thing and the difference between being in the insulated environment for six months and then the reality of, kind of, the world.” | “I’m really feeling it now that he needs something structured – school, work, activity. So, I’m doing my best to structure things at home here and keep him busy.” |

Another theme was the concept of a honeymoon period. A honeymoon period refers to a period of time when common problems appear absent or are ignored. After the honeymoon period, typical problems resurface. Some mothers (n=4) reflected on how their child seemed excited or productive in the first few days or weeks at home, but then began to exhibit previous behaviours; for example, one mother spoke about her child’s decrease in school attendance. The other three mothers focused on a change in the youth’s emotional well-being or lifestyle. For example, youth began to become secluded, appeared down or did not take care of themselves as much. From these reports, this shift or end of the honeymoon period was around the 2-week mark after RT.

The final theme describing the transition period was the change in environmental structure, another transitional challenge youth faced. A few mothers (n=3) reported that their child had to adjust to a less-structured environment at home compared to RT. Mothers’ reports indicated that youth enjoyed structure and a routine. For example, one mother attempted to mimic the structure at RT to help him transition better.
Youth Transition Experience

Mothers reflected on how they thought their child experienced the initial transition. Themes under the youth transition experience were emotions or behaviours exhibited by youth, some in alignment with symptoms of EBD. Seven themes were identified: happiness, nervousness, irritability, lack of motivation, feelings of overwhelm, discomfort and unpredictability. Table 5 provides a summary of the themes with definitions and illustrative quotes.

Many mothers (n=7) reported that their child was happy to be home after RT. Furthermore, four mothers who reported that their child was happy also reported a honeymoon period. Therefore, the youth may have appeared happy only in the first few days at home. Additionally, many mothers (n=6) also felt that there was some nervousness. Youth were nervous about fitting into the home again, making new friends, going to a new school or having to leave home again. Mothers (n=6) reported some irritability displayed by their child. Youth appeared sensitive or experienced “emotional swings”. Several mothers (n=5) also noticed a lack of motivation during the transition. This lack of motivation often pertained to school but sometimes related to social interactions. Among the five mothers who commented on a lack of motivation in their child, three mothers also reported a honeymoon period. Lastly, some mothers also felt their child appeared overwhelmed (n=4) and uncomfortable (n=4) after returning home. A few youth (n=3) reportedly behaved in an unpredictable manner during the transition period.
Table 5

*Themes Related to Youth Transition Experience (n=10)*

<table>
<thead>
<tr>
<th>Theme (%) and Definition</th>
<th>Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Happiness (70%)</strong></td>
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</table>
| Happiness is state of contentment, display positive feelings or excitement during the transition. | “He was staying up… he wasn’t taking naps, he was just so happy and busy and it was easy to say ‘do you want to do this?’ and he’d be like ‘ya! Let’s do this!’”  
“Well, when she came in the door, she seemed happy.”  
“He was, to me, he just felt really happy being home. Like, he felt really happy and I felt he was working really hard so that he doesn’t even have to leave.” |
| **Nervousness (60%)** |
| Nervousness is a display of some anxiety, worry or concern during the transition. | “She was very fidgety. I noticed sometimes that when she gets nervous, her legs would shake. Um, and she would bite her fingernails. She was very fidgety, and I know that before, the week before school started, she didn’t know if she could do it.”  
“She was afraid if she screwed up, that she wouldn’t be coming home anymore.”  
“Well you could see he didn’t know exactly what he was supposed to do.” |
| **Irritability (60%)** |
| Irritability is a heightened emotional state where there may be quick emotional responses, such as anger, frustration or sadness. | “Well, at first it put me on eggs. Walking on eggs because I’d be worried about saying something because she’d jump down my throat literally. Because I said something wrong.”  
“He can be a real jerk. He can call me a [inappropriate name] and then tell me to f-off. In one you know in the morning and then in the afternoon he can be all hugs and sweet and share his candy and it’s just like it’s an emotional rollercoaster. But you know, how much of that is in his control… you know, it’s tough.”  
“Simple matter of a couple words could blow less everything out of proportion.” |
**Lack of Motivation (50%)**

Lack of motivation is appearing unenthusiastic or apathetic towards some part of life.

“I think she is okay in the classroom, but she does complain about having trouble focusing and I did notice a real lack of motivation.”

“I guess help her give her tools to cope with her schedule… She’s extremely capable of doing the work, it’s just more the motivational piece. It’s more maintaining the work ethic to finish.”

“He doesn’t. I suppose, is he physically able to? Yeah I think so. He’s learning like in the last little while, he has learned a lot stuff like he’s learning the bus. So, you know, he might need somebody to drive him there … I’ve always had to push him to engage him in social groups and social activities.”

**Feelings of Overwhelm (40%)**

Overwhelm is a state of feeling overly tired, overstimulated or unable to meet demands.

“I think it was a bit overwhelming, um sort of detaching from where she was to back at home and I think she was a little uncertain about being able to manage… She was overwhelmed… It was a bit overwhelming when she came home… It was almost like sensory overload. That took her a few weeks to kind of settle in… and then finding her footing with a new daily structure. She would notice it’s really loud in here or, you know, she would turn her radio down in the car. She’s just like, ‘it’s too much.’”

“I don’t know whether these four credits are going to happen, because it’s overwhelming.”

**Discomfort (40%)**

Discomfort is feeling awkward or uneasy during the transition.

“Just to have the comfort at home, to be comfortable here and feel at peace. At home is where you should feel peace.”

“My hope right now is just for her to feel comfortable at home.”

**Unpredictability (30%)**

Unpredictability refers to comments about how youth behaved and presented themselves variably during the transition.

“There are days that she’s herself, she will pick up on her own and some days she won’t.”

“The boys were scared, they didn’t know what to expect, we’ve been through a lot and it was a really hard few years for us. So they didn’t know what to expect from her… She has good and bad days.”
Mothers’ Transition Experience

Mothers reflected on their own lived experiences with the transition. Mothers’ transition experiences encompassed different emotions, behaviours or thoughts. Six themes were identified: positivity, overwhelm with current situation, worry about the future, happiness, relief and mistrust. Themes with corresponding definitions and quotes appear in Table 6.

Many mothers (n=8) spoke positively about their children and their circumstances. A few mothers were good at positively reframing a situation, an example of which can be seen in Table 6. A part of the interview guide was focused on hopes and dreams (see Appendix C); answers from those questions were not coded for this theme in order to accurately represent the positivity mothers exhibited. Despite this positivity, many mothers still felt overwhelmed with their current situation (n=7) and worried about the future (n=6). Some mothers felt overwhelmed because of the heightened responsibility of having their child home again. These mothers worried about their families during the transition and what the future holds for them. Nonetheless, mothers were happy (n=5) and relieved (n=3) to have their child return home. Lastly, a few mothers (n=3) reported some mistrust towards how their child would behave in the home.
Table 6

*Themes Related to Mothers’ Transition Experience (n=10)*

<table>
<thead>
<tr>
<th>Theme (%) and Definition</th>
<th>Quotes</th>
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| **Positivity (80%)** | “That be my one, you know, one item on my wish list. That they could have somehow found the key, unlock the key, because he’s a bright boy. Found a way to get him re-engaged with school work, academic work. That didn’t happen … But he’s often surprised us, and he is a bright individual. It’s that his pace is very slow, but if he’s interested and you teach it at his pace, he can learn.”  
“I’m thinking positive and I don’t want to think of anything that happened before.”  
“I have to say, we’re fortunate because we’re middle class, less so… but what if I wasn’t self-employed? … So far, I’ve had the luxury of being able to go to meetings, to talk on the phone, for as long as it takes with whoever, to pursue you know… just even to research the stuff I’m supposed to learn about.”  
“She was a social butterfly. So I think eventually she’ll get back there again, it’ll just take time.” |
| **Overwhelm with Current Situation (70%)** | “It was a bit of an overwhelming feeling. Like oh my gosh, there is no support. The support is gone and um, but I mean, it was just a fleeing feeling and it’s happened. It felt good to have her home, um, but a bit nervous… All of a sudden you weren’t at all coming home and all of a sudden, the kids left the home and you were coming home. So, I, I, honestly I’m surprised she’s here and it happened really fast.”  
“We’re still um kind of have the responsibility of them as if [her children] were in elementary school. And we’ve been doing it a long time. I think now on top of just the exhaustion of doing it for so long, we’re dealing with the resentment of having to do it.”  
“I don’t know. I don’t know. That’s all I know is trying to get her out of her room, out the door… I’ve been doing this for years so I’m just trying to figure out why… I’m emotional, I’m sorry.” |
**Worry About the Future (60%)**

Worry about the future refers to anxiety, uneasiness, nervousness or uncertainty about future outcomes.

“We were all still a little bit scared of things reverting back to the way it was before he left.”

“I was a little bit nervous because he did get bored and his mood did sink… I was very nervous because in the past, before he came home, that’s when he had bouts of violence and you know, defiance and stuff like that. So, it was just… I guess both him and I – more me – getting over my fears of what happened in the past.”

“I think I always will… Always the back of your mind, you know when someone’s been, you’ve watched somebody go through what she has. Like there’s triggers and um life happens, good and bad. You don’t know how someone’s going to react to those things and I can’t control that. It’s been really hard to let that go as a mother right you want to protect your child from everything, but you can’t.”

**Happiness (50%)**

Happiness is state of contentment, joy or excitement during the transition.

“I felt happy. I missed her. I mean, I enjoy her company when things are good. I really love having her here, I love spending time with her and um, and she was working really hard to make it work on her end as well. So she was really motivated to, be agreeable and to do sort of, fit in, and make it work.”

“I was very very happy to have him back… it was all good he was very good and it was just all happy.”

“A lot of excitement… his return home was delayed so when they finally got to it, it was really exciting… Knowing he was home for good at that point made it really exciting. We had a great day.”
Relief (30%)

Relief is feeling relaxed or reassured during the transition.

“We were leaving [big city] and bought this house and we were moving and he still wasn’t here… So, moving into a new home it’s like you move in, but the house is not complete because there’s a piece of the puzzle missing, because he wasn’t home. So now he’s home so it’s like the puzzle is done. That’s how I can explain that.”

“There was a lot of relief… For 8 months we’ve been preparing him for July first.”

“Relieved. Very relieved. I went through a bunch of stuff… but as a parent in order to get him a placement at [agency] I had to pretty much sign off my parental rights.”

Mistrust (30%)

Mistrust is having some doubt, suspicion or lack of confidence in their child.

“I guess there was those periods of time… I didn’t know what she’s really doing. I don’t have, the trust isn’t 100% there… It’s hard to really but I’m trying but it’s hard. I’m always in the back of my mind thinking, oh my gosh, what’s happened here…”

“She went this afternoon, she got up this morning but she didn’t go the other days or the other days I was, I was like ‘why are you doing this now?’ She does ‘I don’t know I just don’t feel like it’ and I go ‘are you just making that up?’ Like you know what I mean… So you don’t know if it’s her, or it’s picking and chooosing. And so I’m asking her ‘are you just saying that?’”

Mother-Youth Relationship

Findings pertaining to the mother-youth relationship were apparent and provided further contextual insight into the transition experience. As the family is a system, the relationship dynamics between mothers and youth may influence the home environment. Six themes were identified: level of engagement, monitoring of child, mother reflection, relationship rebuilding, communication and youth helpfulness. Table 7 provides a description of the six themes with definitions and illustrative quotes.
All mothers (n=10) provided some description of the engagement level within the relationship with their child. Two subthemes were apparent: engaged (n=8) and disengaged (n=6). These subthemes were not mutually exclusive. Many mothers appeared to be engaged and were able to provide detailed descriptions about some aspect of their child’s life. On the contrary, many mothers also appeared to be disengaged and provided minimal detail in some answers. Three mothers displayed some engagement and disengagement; these mothers’ comments were included in both subthemes. It was possible to be engaged in the child’s life, but still show some uncertainty or unawareness in other life domains. Furthermore, all mothers who reported a honeymoon period also showed some disengagement in the relationship with their child. Many mothers (n=9) displayed monitoring behaviours; for example, some mothers would ensure their child went to school or administered medications daily. One mother was sleeping in the living room to monitor her daughter because the youth had a previous history of self-harming behaviour. Many mothers reflected on their lives (n=8) and focused on rebuilding the relationship with their child (n=7). The children of mothers who were engaged and focused on relationship rebuilding, did not appear unmotivated or unpredictable. Improvement in communication (e.g. communication about plans or personal experiences) was also reported (n=6). All mothers who commented on some communication were also coded as engaged mothers. Youth were also reported to be more helpful by several mothers (n=5).
<table>
<thead>
<tr>
<th>Theme (% ) and Definition</th>
<th>Subtheme (%)</th>
<th>Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level of Engagement</strong></td>
<td>Engaged (80%)</td>
<td>“She likes structure definitely… She was a little concerned at the beginning about having a full course load because she hasn’t had that for six months but as I said to her, she got a number of credits at [RT school]. Her concern was the heavy agenda she wasn’t accustomed to, you know but she’s progressing well in all of them so far. I had left it up to her if she felt it was too overwhelming.”</td>
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<td>Disengaged (60%)</td>
<td>“I don’t know. I shouldn’t say I don’t know, he never really tells me “I need help” and um, I know I have this help system out there for him… if he really wanna talk to somebody like if he really has something to tell somebody, I don’t know. I hopefully… I think, we are. But we haven’t experienced it. So I don’t know.”</td>
</tr>
<tr>
<td><strong>Monitoring of Child</strong></td>
<td>(90%)</td>
<td>“I text her when I get to work, just make sure she’s on the bus.”</td>
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<td></td>
<td></td>
<td>“I guess we are kind of protective of him and you know you don’t want him off, and don’t know whether he can fend for himself.”</td>
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</table>
**Mother Reflection (80%)**

Mother reflection includes instances when mothers demonstrated some self-reflection or re-evaluation of the family during the transition.

“She had her moments but we expect they’re going to have moments, it’s not going to vanish. You know, and it’s never going to go away, it’s just a matter of her handling it, really. And having the tools to which to do it.”

“Because he’s been home, I’d have to think how long he’s been home, are we doing okay?”

“Letting go of the expectation of what I always hoped for her and changing that to accept what is right now.”

“I do know for me, one of the things I am working on is, is, letting go of letting go of the expectation of what I, I always hoped for her and changing that and accepting what is right now”

**Relationship Rebuilding (70%)**

Relationship rebuilding refers to mothers who spoke about a perceived fresh start, new beginning, or renewal in the mother-child relationship.

“I don’t want to think of anything that happened before. I’m just going to think of how things are going to start and think of this is a brand-new start for us.”

“I’m making it a habit right now of her and I, planning like a mother-daughter, something once a week. We do something together for a couple hours.”

**Communication (60%)**

Communication in the mother-child relationship refers to when mothers and children were conversing, negotiating or having open-ended conversation.

“I think the communication is better, much better than it was. I mean although we tried to talk, there would be a lot of miscommunication previously. Now, it’s um she seems to be more aware of things she says and the impact they have.”

“She was a little more secretive. But I mean we’ve always kinda had open conversations between us and she’s a little more upfront, yeah I guess with personal things now.”
Youth Helpfulness

(50%)

Youth helpfulness pertains to how children were willing to help their parents with a variety of tasks.

“It shows that he really really wanted to come home and he’s been trying really hard. ‘you need help with this?’, ‘you need any help’… I know he doesn’t want to help me with the garden but he still comes and asks.”

Youth Coping Strategies

The main purpose of this study was to explore mothers’ reports on how youth cope and manage with the transition home. This section is focused on how youth coped with transition experiences. Coping was regarded as the efforts used to deal with a stressor. Mothers described how their child dealt with tough situations and their emotional well-being. Five themes were identified: catharsis, social support, avoidance, social isolation and coping strategies acquired from RT. Coping strategies appear in Table 8 below with definitions and demonstrative quotes.

Catharsis. All of the mothers (n=10) spoke about some form of catharsis their child used. Catharsis was defined as an activity youth used to release emotions or feel relaxed. Youth may intentionally use this coping strategy to release stress or may be unaware of the role the activity in their emotion regulation. Two subthemes were highlighted: creative activities (n=7) and extracurricular activities (n=6). The use of both activities was not mutually exclusive. A few questions in the interview guide asked explicitly about the youth’s hobbies (see Appendix C); answers from those questions were not coded for this theme. The theme of catharsis was based on mothers’ comments which suggested that creative or extracurricular activity was used as a coping strategy.
Many mothers mentioned a creative activity their child enjoyed during a stressful situation. Creative activities were activities during which youth could produce something, apply their individuality or engage in others’ original work. For instance, one youth seemed to be attending school regularly because she enjoyed her art class. This youth enjoyed painting in her room and listening to music under strenuous circumstances. Other creative activities included reading, writing, cooking or singing. Many mothers also reported some type of extracurricular activity used as catharsis. Extracurricular activities referred to hobbies or interests which were not creative or school-related. Some mothers reported how their child sought extracurricular activities to release emotions; other mothers thought their child was coping well because they were involved in extracurricular activities. A variety of extracurricular activities were used: video games, sports or exercise were common. Only one mother had her child enrolled in an organized activity, otherwise youth were using creative or extracurricular activities that were available at school or easily accessible at home.
## Table 8

### Youth Coping Strategies (n=10)

<table>
<thead>
<tr>
<th>Theme (%) and Definition</th>
<th>Subtheme (%)</th>
<th>Quotes</th>
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</thead>
<tbody>
<tr>
<td>Catharsis (100%)</td>
<td>Creative Activities (70%)</td>
<td>“I guess the art… she’s discovered that she loves painting, and, and um, that sort of thing.”</td>
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<tr>
<td></td>
<td></td>
<td>“Um she’s more a, she’s very artistic, um so we now have her um uh in a school that has a lot more arts programs um she had a few people there that she knows.”</td>
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<td></td>
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<td>“If she feelings things then she’ll go through the list I guess. Listen to music, read a book, exercise, like she’ll through all the steps that she has to if she has a thought in her head.”</td>
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<td></td>
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<td>“If you read her stuff you wouldn’t know it was a thirteen fourteen-year-old writing it. But if you say that to her she’ll, ‘don’t do that, it’s embarrassing, I’m not that good’. Her art is fantastic.”</td>
</tr>
<tr>
<td>Extracurricular activities (60%)</td>
<td></td>
<td>“School’s been fantastic. He’s really passionate about gardening, horticulture. So, he is doing co-op now at school… He’s also doing new things in the community that um he hasn’t he didn’t do before because he got a support worker who has helped him and guided him. She got him involved, there’s a senior’s day program where he goes once a week.”</td>
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<td></td>
<td></td>
<td>“Um he will go and play basketball. Um there’s been a number of times where he’s been upset and he’s excused himself to go to the school. Which is perfectly fine.”</td>
</tr>
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</table>

| Social support (90%) | Family support (80%) | “I said, ‘I don’t know what might work for ya’ but you know I try and give her examples of where I feel overwhelmed but it’s not necessarily the same. And she’ll go ‘yeah well mine’s like ten times worse than that’ but I try and get her to, yeah to give her options to think about something different |
emotional support to cope with a stressor.
or any other coping skills I was aware of."

“Um, even if I don’t have the answer right away, he at this point has the confidence in me that I’ll find the answer. So I think that makes things a lot easier because of everything we’ve been through, we’ve been put in positions where we’ve been told there’s no way out of it and I’ll find something to get us through it anyway. So realistically, there’s nothing we can’t get through.”

“She’ll come and sit there and she doesn’t do that. And I go is something up? And she goes I wanna talk okay, talk away. And she’ll you know discuss whatever, she’ll talk about what happens on the internet with her and her friends and other fellers you know.”

Peer support (50%)

“I think that her friendships are a huge part of [her improvements in behaviour] and um, she’s done the work. There’s been so many people that have helped her and she knows that she knows we all love and how much people care.”

“Being with other people makes him happy. I think it’s such a cruel twist of fate that an extrovert like him got stuck with some of the Asperger qualities of no social skills. Like you want to be around people, but you don’t know how to do it.”

“I know there’s like four, I’ve seen another one though, about five. They’ve been around through the whole thing. Extremely smart girls and their being accepted into university now… I think that’s what’s part of [youth]’s going through you know… I’m really glad that her friends have stuck with her through all this.”
Avoidance (90%)

Avoidance was used as a coping strategy when youth wanted to avoid or disregard a stressor to minimize harm.

Mental disengagement (70%)

“I think [youth] doesn’t really talk much, so he didn’t really express how she felt and I have a feeling she’s probably angry with myself and him or whatever.”

“I try to talk to her about but once again, it’s, it’s hard because it’s only goes as far as she’ll share and, and, quite often, It’s just ‘I don’t want to talk about it.’”

“Almost like changing the subject. To something else. Like she doesn’t wanna hear the word school. She wants you to jump to something else and talk about something’ else.”

“I would communicate with him almost every day and I would say ‘are you okay?’ ‘Yes. I’m fine. You asked me that yesterday.’”

Behavioural disengagement (70%)

“She’s you know cranky or something, she stays in her bedroom. Stays in her room. Just hides in her room, that’s about it. And I’m saying why aren’t you coming down are you coming down, she goes I will.”

“But if things don’t go her way, she usually goes up to her room.”

“I tried my hardest to keep him awake uh, but then I’d allow him to have a nap and then I’d have to wake him up close to supper time and ya know, try to keep him awake for a few more hours doing activities.”
Social isolation (70%)

Social isolation as a coping strategy was used when youth avoided social encounters, peers or the community due to stress.

“Yes um [worker] brought it up… she actually gave me a list of sports like even on a certain day like a Wednesday when he has half-day at school, he can join. Also at the library and stuff, he wasn’t interested. Even people at the boys’ house came over and wanted to take him… he wasn’t… but because of the situation I am in, I’m not going to fight with him, right?”

“She has one friend, before she was in the home. She lives right there. So she can just walk over, she can just walk right here, just right across and walk around to my door… I don’t know maybe she’s not going to go see them. Because we told her, why don’t you go out and knock on their door. She won’t.”

Coping Strategies Acquired from RT (40%)

Coping strategies acquired from RT refer to any coping skill youth learned during treatment at RT.

“It works and I credit a lot of that with you know, I credit DBT as a big part of that. But that’s really only part of what they did there. Whatever they’re doing there, works at least it worked for him.”

“I think it’s DBT or some kind of therapy, I know she goes through all the steps and she’s done a lot of reach online.”

“Like journaling and meditating and stuff like that. Where before in the past if I had told him stuff like that he would just…” I’m gonna kill myself… I’m gonna hurt everybody!” and he like… totally, uncontrollable.”
**Social support.** Another common coping strategy reported by many mothers (n=9) was the use of social support. Youth can have a problem-focus or emotion-focus when seeking social support. A problem-focused approach would mean youth sought advice or problem-solving skills from others. An emotion-focused approach would mean youth wanted emotional support. Social support had two subthemes: family support (n=8) and peer support (n=5).

Many mothers felt their child sought family relationships to cope with the transition home. The mothers mainly reported themselves as the most common family member approached by youth for support. Based on the mothers’ comments, youth seemed to approach their mothers at different times for a problem-focused or emotion-focused purpose. Other family members approached by youth were similarly-aged family members such as siblings or cousins.

Several mothers also thought their children sought peer relationships for support. Peer relationships included friends around the same age as the youth who were not family. Some youth reportedly had a peer as their confidant, while some youth may enjoy being in the company of peers when upset. Peers with similar experiences appeared to be supportive towards youth. Additionally, four of the five youth sought support from peers known before admittance to RT. Therefore, some peers may have maintained contact with the youth during and after RT, which may have allowed their relationship to be a helpful source of support throughout the transition. From the mothers’ reports, it was difficult to comment on the type of support youth sought from peers. All five youth who reportedly used peer support were regarded as irritable by mothers; four of the five youth used family support as well.

**Avoidance.** Many mothers (n=9) reported some type of avoidant coping strategy their child used during the transition. Avoidant coping strategies were used when youth wanted to ignore the stressor. For example, the youth might act as though there is no stressor or avoid
confrontation of the stressor. Two subthemes of avoidant coping strategies were identified: mental disengagement (n=7) and behavioural disengagement (n=7). Five youth reportedly used both mental and behavioural disengagement as coping strategies.

Mental disengagement refers to behaviours in which youth engaged to avoid thoughts and cognitions related to the stressor. Mothers noted comments such as “I don’t want talk about it” or “I’m fine”. Mothers spoke about how their child used mental disengagement as a coping strategy. Youth might avoid the stressful subject by changing the topic or resist talking about the stressful circumstance. Some mothers invested a lot of time to get their child to engage with the stressor, while other mothers simply did not know what to do.

Behavioural disengagement refers to behaviours which youth used to physically withdraw from a stressful situation. Many mothers commented that their children would physically remove themselves from a stressful situation as a coping strategy or for anger management. For some youth, this avoidant strategy corresponded with lethargy, such as excessive napping throughout the day. However, this disengagement strategy permitted some youth to engage in the stressor at a later time, such as seeking social support later.

**Social isolation.** Many mothers (n=7) talked about how their child became socially isolated during the transition. Social isolation refers to youth avoiding social encounters, peers or the community during this time. As a coping strategy, this meant that when youth were stressed about something in the environment, they isolated themselves. Comments regarding how the child “has no friends” or “just doesn’t care to be social” were common. Some youth had no involvement in social groups or the community, even when it was readily available. These mothers described how their child had no interest in making friends or rekindling with old
friends. Youth may have shown a sudden lack of interest in a hobby, such as organized sports, which was of interest before treatment.

**Coping strategies acquired from RT.** Some mothers (n=4) spoke directly about how their child employed coping strategies that were taught at RT. Youth were likely still struggling with their mental health problems after RT; therefore, having a repertoire of acquired coping strategies is critical. Two mothers specifically mentioned how their child used dialectical behavioural therapy (DBT), a type of cognitive therapy taught at RT, as a coping strategy. These mothers felt that DBT was an effective coping strategy for their child. However, the mothers did not note what aspect of DBT was helpful. One mother mentioned how her son used other learned coping skills, such as journaling or meditating. The fourth mother did not mention the kind of skills used, but just commented that her daughter was using coping strategies learned at RT.

**Support Networks**

Another set of findings related to support networks. Four themes were identified: mother support, community support, lack of service support and RT support. The themes with definitions and illustrative quotes appear in Table 9. All of the mothers (n=10) reported providing support to their child. Many mothers (n=7) were proactive in their support, for example, helping with homework or finding activities to reinstate structure. The remaining three mothers attempted to provide support, but the support was not well received.

Many mothers (n=9) commented on some type of community support which were not RT- or family-related. Most of the community support came from the youth’s school. Some youth attended alternative schools with child youth workers (CYWs) or had individual education
plans (IEPs). Aside from schools, other community supports were CAS, community groups or the hospital. Notably, many mothers reported some type of community support; however, a lack of service support was still conveyed (n=8). Mothers who did not report a lack of service support (n=2) had consistent community support. For example, one social worker was spending an evening each week with the youth, while another youth was attending weekly dialectal behavioural therapy (DBT) sessions. Several mothers worried about losing previous RT supports and beginning the transition with no support in place. Some mothers felt that the support they had was not effective. One mother stated that support “focuses around the child” and that the “parent kind of gets forgotten”. This lack of parent support was seen in the data as only two mothers were attending a parent/caregiver support group.

Many mothers (n=6) commented on support from RT. Two subthemes were identified: a lack of support (n=5) and discharge preparation or support (n=3). Mothers felt a lack of support from RT in some aspect. For instance, RT may not have followed up or did not connect the family with support. However, a few mothers did comment on some discharge preparation or transition support received from RT, such as weekly community groups. All mothers who received transition support from RT also reported that their child used coping skills learned from RT.
### Table 9

*Themes Related to Support Networks (n=10)*

<table>
<thead>
<tr>
<th>Theme (%) and Definition</th>
<th>Subtheme (%)</th>
<th>Quotes</th>
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<tbody>
<tr>
<td><strong>Mother Support</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(100%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother support refers to comments about how mothers provided or attempted to provide support to their child. Support could be making themselves available, providing advice or taking action to help the youth in any life domain.</td>
<td></td>
<td>“She’s actually showing me some of her math and a few other things. I know it’s all different processes but getting you know, just having her talk through it sometimes. Doing her practice tests and then I’ll mark them and might look at it.”</td>
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<td></td>
<td></td>
<td>“I will make you tea, you did make it through a day that you felt was a little rough.”</td>
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<td>“I go how’s class how was it today? It’s good. That’s it. That was it and the end of the conversation. So then I’m like uh so what did you do in your paper work something, you gonna get your stuff done? and she goes yeah I did that, and I did computer so I’m trying to weave it in there, talk about how her day was.”</td>
</tr>
<tr>
<td><strong>Community Support</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(90%)</td>
<td></td>
<td></td>
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<tr>
<td>Community support refers to support from other organizations or people, who are not family or RT-related.</td>
<td></td>
<td>“We’re very fortunate with our support worker here, cuz she takes the initiative and she gets it and she works really hard at that so tonight is supposed to be cooking and this is a new thing, cooking dinner night.”</td>
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<td></td>
<td></td>
<td>“Well the vice principal said ‘we are here, the people in this room are the people you come and talk to, we know about your situation, we will take it seriously even though you don’t see us talking to the student, we will talk to them.”</td>
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</table>
Lack of Service Support (80%)

Lack of service support refers to instances where mothers felt a lack of community services or felt services were ineffective.

“I wish there would have been, you know, a counselling session booked for after like a week he was home.”

“I wish that, ya know, there was a little bit more guidance…and maybe people with connections could have set something up right away, instead of being put on the 3-month waiting list.”

RT Support (60%)

RT as a support network refers to support or lack of support received by RT as a treatment centre or workers from RT.

“I remember I was told that I would be called to make sure everything was fine and nobody called.”

“It was just more uh you know, there’s numbers and you can still contact [agency] if you need support.”

“Yeah, I mean the transition time, yeah, was very much okay, bye.”

“I haven’t gotten anything from them since [youth] got home.”

“Like just, at least a 7-10 day plan. Like, “here’s your 7-10 day plan when he comes home…get that going…call us when you have that in place and then we’ll write down the discharge date.’”

Discharge Preparation or Support (30%)

“We are going and doing, because I think DBT was so uh such a big part of the success that of his time at [agency]. We’re continuing, we go once a week to a DBT group, um so he does the adolescent component, we do the fam- the um caregiver component so that we can help him.”

“She would basically kind of tell us you know what to expect, what was coming, um some of the challenges we might come across where you know after six months there is a bit of an attachment. Um and kinda that transition when she’s home.”

“[Youth’s] counsellor came to um, the psychologist appointment, and she didn’t have to so that was nice. And I think comforting for [youth] just, ya know that it was, he wasn’t just dropped.”
Youth Intrinsic Factors

Two important youth intrinsic factors which relate to the coping process were evident. The characteristics can be seen in Table 10 with demonstrative quotes. The first intrinsic factor was the level of dependency (n=8) with two subthemes: independent (n=5) and dependent (n=4). Youth reported as independent were self-sufficient in some aspect of their life. For example, the youth got up to get to school, took medications and did their chores independently. On the other hand, dependent youth needed help with tasks related to personal health such as taking medications and booking appointments. One youth appeared to be independent and dependent in different life domains. The second intrinsic factor was low self-esteem (n=6). Youth were often insecure with their performance at school or their acceptance with peers. Youth were hard on themselves and some needed constant reassurance that “there will always be somebody that doesn’t like you”.

Table 10

<table>
<thead>
<tr>
<th>Theme (%) and Definition</th>
<th>Subtheme (%)</th>
<th>Quotes</th>
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<tbody>
<tr>
<td>Level of Dependency (80%)</td>
<td>Independent (50%)</td>
<td>“She needs to be on the bus about five to seven. So it’s early for her and it’s about an hour bus ride… Um so and she actually um, mornings she’ll be up before you know, I expect her to be up. You know, and she’s already going so I think she’s really adjusting well um with going to school.”</td>
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Dependent (40%)

“Cuz I think you need to be productive and you need to not feel dependent on others you know, of course we depend on each other, but what if we’re not around?. You know, he has to learn um how to live independently. Also to make him less vulnerable.”

Low Self-Esteem (60%)

Low self-esteem is having a lack of confidence in one’s own abilities.

“Inside. I can’t, I mean, I can keep the relationship going and keep the relationship positive but I can’t ultimately make her love herself or see self-value”

Trustworthiness

All ten mothers were sent the member check summary (see Appendix E) to their provided email addresses. Two participants responded; one confirmed these themes and one participant felt that need for professional transition supports should have been the focus. As part of the negative case analysis, neither of the two coders felt there were any opposing cases. These results suggested credibility of the described themes.
Discussion

The current study was focused on mothers’ reports of how their child coped with the transition after RT. Transition experiences needed to be explored in order to provide key contextual information of the post-RT environment. Themes related to the transition period were noted as mothers spoke about the challenges their child faced after RT and a honeymoon period in terms of functioning. Youth reportedly felt a variety of emotions, a few of which could indicate some symptoms of mental health disorder. Mothers also experienced a variety of emotions but a majority of mothers spoke positively about their child and circumstances. Many mothers commented on the use of catharsis, social support, avoidance and social isolation as coping strategies by their children. An important, but less common, coping strategy reported was the use of coping strategies acquired from RT. Findings related to the mother-youth relationship, support networks and youth intrinsic factors were also reported. The current study provided unique insight into how mothers regard the transition and their child’s coping. The following discussion is focused on challenges youth reportedly faced after RT, a honeymoon period in functioning, the emotional experiences of youth and their mothers, as well as key mother-child relationship factors. Lastly, the discussion will be centred on the reported coping strategies and a theoretical lens will be applied to foster understanding of mothers’ reports of how their child coped after RT.

Mothers provided detailed descriptions of the transition experience after RT. Participants spoke about how their child needed to transition into a less structured environment than RT and re-establish social networks. Re-establishing social networks could be challenging because children with behavioural disorders are more likely to be rejected (Dodge et al., 2003). From the mothers’ descriptions, youth appeared comfortable with the structure and peers at RT, but were
also worn-out. There was more ambivalence regarding how ready mothers were themselves. This uncertainty could be because mothers lived apart from their child for an extended period of time. An interesting finding was the concept of a honeymoon period. Around 2 weeks after discharge, previous problems began to resurface in youth, which were not present immediately after discharge. One parent in Thomson et al. (2011) commented on how her daughter was functioning well immediately after discharge but began to return to previous behaviours; this idea was corroborated by some mothers in the current sample. The honeymoon period reported in the current study could be a reflection of several different factors. First, it may suggest a lack of preparation or successful transitioning after RT. Second, the honeymoon period could be a result of youth eagerness to leave RT. Youth may be eager to return home, but inevitably face the realities of transitioning home. Lastly, mothers may have believed that their child’s problems were resolved after RT; this can be a false hope since emotional and behavioural disorders are often chronic in nature (Pastor et al., 2012). In comparison to Thomson et al. (2011), the participants described a honeymoon period within a much shorter period of time.

A variety of youth emotional experiences were reported by mothers. Although mothers reported that their child seemed happy, they also stated that their child was uncomfortable, overwhelmed and nervous with the change. These emotional experiences seem sensible because youth transitioned into new homes and potentially new schools, peer groups or community activities. All these changes at once can be overwhelming, especially without constant supervision and support. Some youth seemed afraid to make mistakes due to fear of being removed from their home; other youth seemed nervous about fitting into their home, school or peer group. This concept was outlined in Pumariega (2007), where the importance of re-establishing roles was underscored. Mothers’ comments reflected an emotional experience for
youth, which youth must manage along with the normative developmental tasks of adolescence (Masten & Coatsworth, 1998).

A few reported transition experiences may indicate symptoms of mental health disorder. For instance, one mother pointed out how her daughter was fidgety and another mother explicitly stated that her son’s “anxiety was building up”. These examples of nervousness could indicate anxiety, an internalizing symptom. Internalizing problems can also be interpreted from the SDQ which are represented by the emotional and peer problems subscales (Goodman, 1997). The qualitative comments aligned with SDQ scores because 60% of children were rated as having a high or very high degree of both emotional and peer problems. Youth appeared to struggle with internalizing problems from their mothers’ perspective.

Externalizing problems may also be represented in the mothers’ reports. For example, many youth appeared irritable during the transition. Mothers felt their child would externalize emotions and appeared irritable by displaying emotional mood swings or being easily distressed. Externalizing problems can be interpreted from the conduct problems and hyperactivity-inattention subscales of the SDQ (Goodman, 1997). More mothers rated their child as high or very high on conduct problems (60%) compared to hyperactivity-inattention (10%). Most youth entering RT struggle with conduct disorder (Preyde et al., 2011c; Preyde et al., 2011b) which may explain differences in externalizing problems rated by mothers after RT. Lower ratings of hyperactivity-inattention may reflect outcomes after RT; although, this cannot be concluded without SDQ data from before admittance. Mothers did not comment specifically on their child’s mental health symptoms; however, from some of their descriptions and SDQ scores, some potential behavioural symptoms were noted.
Mothers also provided descriptions of their own lived experiences. Although mothers were asked about their hopes and dreams, many positive comments were made as part of answers to questions about life domains. This positivity may reflect positive reframing. Although it was not explored in the current study, positive reframing might be a coping strategy that mothers employed or a reflection of social desirability. Youth were out of the home for an extended period of time; therefore, it was sensible that mothers felt overwhelmed with their current situation as responsibility was regained as caregivers. As many youth from RT struggle with conduct disorder (Preyde et al., 2011c; Preyde et al., 2011b), a few mothers did not trust what their child was doing at home alone or with friends. This mistrust may explain the reported monitoring behaviours. Evidently, there was a variety of emotions felt by mothers. Since this was the initial transition time, families may not have settled into roles or have set expectations.

Topics pertaining to the mother-child relationship appeared significant to the transition experience. Monitoring of children was commonly reported amongst the mothers in this sample. This monitoring may also be a coping behaviour to deal with the worry mothers felt. Monitoring behaviours are typically reported less amongst parents of children with EBD (Pettit, 2001); monitoring behaviours may have been common in this sample because mothers’ self-reports were used and data were collected fairly soon after discharge. A fascinating link was that of disengagement and the honeymoon period; engagement in the mother-youth relationship may help youth function adequately over time. Caregiver support may be pertinent to youth functioning after RT. However, it could be that after the youth’s functioning began to decline, mothers became disconnected.

Hess et al. (2012) and Pumareiga (2007) emphasized a need for parents to be eager to change personally. This eagerness to change was seen in the current sample, as mothers critically
reflected on themselves, their family and their child. Changing expectations into more realistic expectations was common during this type of reflection. Families should accommodate to the child’s return and also receive support services to make these accommodations (Pumareiga, 2007). Additionally, families should recognize the need for continuous efforts and have confidence or trust in the youth (Hess et al., 2012). Several of these suggestions were present in the current sample including a willingness to change, accommodation for the child, recognition of continuous efforts and support services. However, these factors were not consistent across families. The trust described by Hess et al. (2012) was not reported by the current sample of mothers. It is to be noted that interviews were conducted 4 weeks after discharge and it is possible that trust was not yet established. The success of transition was not the focus of this study. However, it was noted that children of mothers who were engaged and worked on relationship rebuilding did not appear unpredictable or unmotivated. There appears to be some influence of the mother-youth relationship on youth transitioning after RT.

Thus far, this discussion has been centred on transition experiences. However, the primary purpose of this study was to explore mothers’ perceptions of how youth coped and managed the transition after RT. In this study, coping referred to those efforts used by youth to adapt to their environment and the associated transition experiences (Compas et al., 2001; Folkman, 1984) after discharge from RT. A common coping strategy reported by mothers in this sample was catharsis. Chosen activities were those that were of interest to youth or that youth performed well. Youth seemed to take pride in their creative work, which may help with self-esteem. Therefore, the activity may allow youth to channel emotions while also producing positive emotions. The development of positive emotions could be one reason why cathartic
activities were common. Alternatively, having such activities available could mimic routine or structure youth seemed to desire.

Another common coping strategy was the use of social support. Mothers mainly reported themselves as family members approached for support by youth; however, youth may have a different opinion. Youth reportedly sought both problem-focused and emotion-focused support from mothers. It is unknown what factors would lead youth to seek problem-focused support versus emotion-focused support from mothers. All youth who reportedly used peer support were also regarded as irritable by mothers. It is possible that youth displaying irritability were more likely to seek peer support or youth who sought peer support became more irritable. Most youth reported to use peer support were also receiving support from their family. Therefore, irritability could be indicative of youth who require more support. As noted in Table 2, SDQ scores indicated highly problematic peer problems. It is plausible that youth have inadequate interpersonal skills which can limit their ability to receive peer support. It is known that children with EBD tend to be rejected by peers and have difficulty with processing social cues (Dodge et al., 2003; Lochman & Dodge, 1994); therefore, it may be beneficial to broaden the interpersonal skills of youth with EBD in order to promote a larger repertoire of coping strategies. Social support was a common coping strategy; therefore, it is important to ensure the establishment of social connections after RT to potentially enhance the coping process after RT.

Avoidant coping strategies were pertinent in the mothers’ reports. Mental disengagement appeared to hinder the use of social support; youth were reported to say comments such as “I don’t want to talk about it”. Behavioural disengagement seemed to allow some youth to re-engage with the stressor or use their support network afterwards. Many youth entering RT score high on conduct disorder (Preyde et al., 2011c; Preyde et al., 2011b) which is characterized by
aggressive or defiant behaviours (Robbins, 1991). Therefore, it may be beneficial to initially use behavioural disengagement as a means to avoid other destructive behaviours. Furthermore, it is unknown what impact the use of both mental and behavioural disengagement has on youth adjustment. It is acknowledged that different coping strategies can be effective for different individuals and situations.

Many mothers felt their children socially isolated themselves as a coping strategy. As a coping strategy, social isolation might allow youth to avoid immediate harm. For example, if youth perceive stigma or discrimination resulting from their mental health disorder, a coping strategy might be to avoid social encounters with those peers. However, the reported social isolation may have been a feature of depression. It should also be noted that youth with EBD are more likely to be rejected by peers (Dodge et al., 2003) and peer rejection is a risk factor of EBD (Hinshaw & Melnick, 1995). Social isolation may have a short-term emotional benefit, but may limit one’s social network in the long-term, which can negatively impact future mental health outcomes (Barnett & Gotlib, 1988). Additionally, social isolation may hinder feelings of social cohesion, which has been shown to correlate with fewer incidences of depression (Aneshensel & Sucoff, 1996). That is not to say that social isolation is an ineffective strategy because no coping strategy can be labeled as inherently “good” or “bad” (Lazarus & Folkman, 1984). Social isolation may have a benefit for youth after RT. It is known that youth with EBD tend to associate with deviant peer groups (Marshal et al., 2003). Therefore, it may be beneficial to employ the use of social isolation after RT if peers are engaging in deviant behaviours. From the mothers’ descriptions, it is difficult to interpret the reasons for the reported use of social isolation. Irrespective, the use of social isolation as a coping strategy was reported among the current sample of mothers.
It is difficult to contrast the current findings with previous studies, as few studies explored coping and adaptation after RT. Youth in the study by Thomson et al. (2011) only reported the use of coping strategies acquired from RT such as DBT, journaling and listening to music in adolescent girls after RT. Similar to Thomson et al. (2011), the use of coping strategies acquired from RT was reported by some mothers in the current sample. One youth in the current sample used journaling and meditating as coping strategies. DBT was mentioned by two mothers as an effective coping strategy after RT. DBT appears to be one type of therapy which clients learn and apply. Mothers who reported use of RT coping skills were among those who received transition support from RT. Therefore, it seems that receiving support from RT after discharge may foster the use of learned coping skills in youth. The current study expanded on the coping literature and described the use of catharsis, social support, avoidance and social isolation, in addition to acquired coping strategies.

Generally, mothers reported the use of coping strategies which were mainly emotion-focused. Emotion-focused coping strategies were those techniques used to manage and regulate distressing emotions associated with a stressor (Folkman et al., 1984). Reported emotion-focused strategies included: catharsis, avoidance and social isolation (Folkman & Lazarus, 1985). When youth appeared to engage in cathartic activities, there was an improvement in mood. For example, some mothers felt their child functioned better at school because they were able to participate in artistic activities. Avoidant coping strategies seemed emotion-focused because youth would diverge from the stressor, whether in cognition or behaviour, to focus on regulating their emotions. Mental disengagement and behavioural disengagement appeared to allow youth to regulate their emotional arousal because the stressor became less apparent. Social isolation might allow youth to focus on emotions as the need to explain their problems or face a stressful
social situation would diminish. These emotion-focused coping strategies appeared passive in that mothers did not report youth actively engaging with the stressor. It may have been beneficial for youth to employ emotion-focused strategies. Youth struggled with moderate to severe EBD which led to their admission into RT; therefore, RT may have provided resources and skills for youth to manage their emotional and behavioural symptoms. It may be a treatment goal for youth to learn emotion-focused coping strategies which could help youth regulate their symptoms and allow them to access less intensive service options after discharge.

On the other hand, social support can be considered both problem- and emotion-focused (Folkman & Lazarus, 1985). The purpose of seeking social support depended on the individual youth or the situation. The function of coping strategies acquired from RT would depend on the specific skill. DBT is focused largely on emotion dysregulation (McMain, Korman, & Dimeff, 2001). Other reported coping skills learned from RT also appeared emotion-focused, such as meditating and journaling. Holistically, mothers commented mainly on emotion-focused coping strategies, with minimal comments on problem-focused coping strategies. When a situation is perceived as one that must be accepted, the use of emotion-focused coping is more likely (Folkman & Lazarus, 1980). To facilitate problem-focused coping, the individual should feel that constructive action can be done (Folkman & Lazarus, 1980). Therefore, youth may appraise the transition time as one that must be tolerated or underestimate their ability to alter the stressor, which could be why problem-focused coping generally appeared absent in the mothers’ reports. Other coping strategies such as redefinition, positive reframing, acceptance, direct action or religion were not reported by the current sample of mothers.

Coping efforts are processes used to facilitate adaptation to a stressful environment (Compas et al., 2001). The RAM outlined by Hanna and Roy (2001) provided different functions
of adaptation. Based on the mothers’ reports, it appeared that youth were mainly engaged in the role function mode. Upon return home, youth were struggling to integrate into the home. Some youth were helpful at home, which may relate to the interdependence mode, as youth wanted to build relationships at home (Hanna & Roy, 2001). According to Lehti (2016), under the theory of psychological adaptive modes, youth are likely in an adaptive struggle. The pre-existing mental health problems in youth would likely have previously triggered an adaptive mode. Therefore, the influx of emotions marked by adaptive modes under this model could have made it more difficult for youth to transition home effectively. Under this model, the success of an adaptive mode is determined by whether an individual returns to homeostasis (Lehti, 2016). The concept of homeostasis is difficult to apply to the current population because it is unlikely these youth and their families want to return to previous circumstances. These families are encouraged to move forward and redefine the structure at home.
Implications

Directions for Future Research

The current study fostered some understanding of how mothers perceived their child’s coping after RT. Further insight into the transition experiences of mothers and youth were also gained. However, there is room for further research inquiry. The current sample of mothers were biological mothers whose children accessed RT for moderate to severe EBD. It would be interesting to contrast the mothers’ reports with youth self-reports in future research. Similar research can also be conducted with other populations of youth accessing RT. For instance, research can be focused on the coping of youth under the custody of the local government who may be discharged into foster care or other residential care.

The scientific literature may also benefit from further inquiry concerning transition experiences. For instance, the types of factors which relate to why certain youth or parents feel ready for the transition home could be explored. Some reasons (e.g. wanting to get away from peers at RT) were apparent in the mothers’ comments. Research on factors associated with the honeymoon period could enlighten why some youth began to decline in functioning at 2 weeks. There may also be a benefit to greater focus on parent transition experiences and parent coping. Since it is difficult to care for these youth (Brannan & Heflinger, 2001), it is important to explore how parents cope and manage. There was some potential insight into mothers’ coping methods in the current findings, though it was not the current focus. A focus on parent coping can have implications for future parent supports. Lastly, understanding the factors related to parent-child engagement or relationship building may be of interest. This is a specific population of mother-child dyads who have been separated for the duration of RT and may have developed different
relationship dynamics. Additionally, one factor that was not seen in the current results was that of parent involvement during RT and how that relates to youth coping after RT.

Further exploration of youth coping and adaptation after RT can also be conducted. The current study was exploratory and many youth were reported to have low self-esteem. It would be interesting to explore how self-esteem relates to youth coping processes after RT. Coping strategies can also be assessed at different times after discharge. Coping was regarded as a process; therefore, coping strategies may change over time between or within individuals. Additionally, a longitudinal design may provide insight into which immediate coping strategies relate to a larger repertoire of coping skills, which can allow youth to be more adaptable. Understanding the relationship between different coping strategies and different stressors may also be important. Lastly, researchers could assess the long-term effectiveness of coping skills training. For example, researchers could examine whether youth learn new ways to cope during RT and if learned strategies replace poor strategies used to manage their EBD before admittance. The exploration of this novel topic allowed for some insight into how youth cope after RT; however, further research can provide a more comprehensive understanding.

**Directions for Future Practice in Residential Mental Health Treatment**

Mothers commented on several topics that have practical implications in residential mental health. Few mothers felt their child used coping strategies learned at RT. If coping strategies and techniques are taught at RT, further emphasis on this topic may be needed. Alternatively, the communication of these strategies may need to be improved. According to a few mothers, DBT was a useful tool for their child. Agencies which are not incorporating DBT into their programming may benefit from investigating whether DBT is applicable to their
clients. RT may want to incorporate programs for building self-esteem or independence after discharge, since several mothers reported that their child lacked self-esteem and was dependent. Being independent and high self-esteem can be associated with long-term adaptation (e.g. Wells et al., 1991). Incorporating evidence-based programs which aid in coping after RT into residential mental health treatment is critical. Since youth potentially return to a family environment which may have contributed to the onset of their mental health disorder (Leichtman & Leichtman, 2001), it is important for youth to have the skillset to cope and manage effectively.

Findings pertaining to support networks also have practical implications. Many mothers felt a lack of transition support from RT, as predicted by Leichtman and Leichtman (2001). It is important that RT maintains some contact with clients or delivers on promises, especially during initial transition period. Based on the mothers’ descriptions, transitional support related to the use of coping strategies acquired from RT. Since the family is a system and families need to adjust to the youth’s return (Pumareiga, 2007), there should be more community support for parents. Only two mothers mentioned receiving any community support tailored for parents. Mothers were often providing support to their child and may burnout if they, too, do not receive some support.
Limitations

Limitations exist within this study and should be noted. The study centred on the parent perspective. This perspective was chosen to potentially provide detailed perceptions on youth emotional adjustment (McCauley Ohanessian et al., 1995; Nijhof et al., 2014). However, this is also a limitation to the study. Although many mothers communicated regularly with their child, it is critical to remember that the findings represented how mothers perceived their children. Therefore, findings cannot be concluded to be the same as the youth’s perspective and should be interpreted accordingly. Additionally, findings may not be the same from a clinical perspective or objective perspective. The parent perspective can be especially disadvantageous for mothers who seemed disengaged with their child because they may have inaccurate or limited knowledge of their child’s functioning. The initial intention of this study was to focus on parents; however, mothers were selected to meet sample size criteria and maintain cohesiveness in the sample. Therefore, the results of this study may not represent the perspective of fathers or parents as a whole. Furthermore, mothers may also struggle with their own mental health problems which could impact their responses.

In terms of methodology, a few limitations can be seen. This study is part of an ongoing longitudinal project with six different RT centres all with potentially different philosophies and practices. Additionally, four different researchers conducted the interviews. Different interviewers may have unique interviewing styles which could have led to some discrepancy. Different interviewers may also be a limitation during data analysis because the analysts did not conduct the interviews (aside from one interview conducted by myself); however, case notes were read to provide context to the coder. In order to enhance credibility of results, the data
were thematically coded by two graduate students who regularly met to increase trustworthiness of results.

The ability to ensure dependability of results is also limited since self-reported data are difficult to verify. Participants will have their own biases when responding to interview questions. There may be a self-selection bias as participants chose whether or not to participate in the study. It is possible that mothers who participated in the study were distinct from mothers who did not want to participate. Furthermore, the transferability of results is also limited. Mental health disorders are idiosyncratic in nature and the results from this sample may not apply to other samples of mothers. Participants were recruited from RT centres in South-western Ontario; results may not be transferable to other areas.
Conclusion

Youth face many challenges as they transition into their home, peer circle and community after RT. It was important to explore how initial transition experiences in order to explore how youth coped immediately after RT. Coping was regarded as part of the adaptation process (Compas et al., 2001; Folkman, 1984); therefore, initial coping processes may influence future adaptation. Youth reportedly used many emotion-focused coping strategies including catharsis, avoidance and social isolation. Social support from family and peers was also commonly reported by mothers. However, few mothers reported the use of coping strategies acquired from RT or problem-focused coping strategies. These emotion-focused strategies may have helped youth regulate the emotional symptoms of their psychiatric disorder. Additionally, youth who were functioning well in their home, peer circle or school were reportedly receiving quite a bit of support from their mothers and the community. Some youth were barely meeting daily demands even with the support of others. It is possible that without continuous support, even the most functional youth may begin to struggle. Individually, youth seemed to be inadequately coping with the initial transition as some youth were dependent, lacking motivation, irritable and unpredictable. It is important to ensure that youth leaving RT are provided the training and support to foster the use of coping skills which can aid in the long-term adaptation process. The mothers’ comments suggest a need for a continuity of care after youth are discharged from RT.
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Appendix A – Certification of Ethical Approval

UNIVERSITY OF GUELPH
RESEARCH ETHICS BOARDS
Certification of Ethical Acceptability of Research Involving Human Participants

APPROVAL PERIOD: April 8, 2015
EXPIRY DATE: April 8, 2016
REB: G
REB NUMBER: 14NV032
TYPE OF REVIEW: Full Board
PRINCIPAL INVESTIGATOR: Preyde, Michelle (mpreyde@uoguelph.ca)
DEPARTMENT: Family Relations & Applied Nutrition
SPONSOR(S): SSHRC Insight Grant
TITLE OF PROJECT: Phase four: A framework for understanding community adaptation processes for youth leaving residential care

The members of the University of Guelph Research Ethics Board have examined the protocol which describes the participation of the human participants in the above-named research project and considers the procedures, as described by the applicant, to conform to the University’s ethical standards and the Tri-Council Policy Statement, 2nd Edition.

The REB requires that researchers:
• Adhere to the protocol as last reviewed and approved by the REB.
• Receive approval from the REB for any modifications before they can be implemented.
• Report any change in the source of funding.
• Report unexpected events or incidental findings to the REB as soon as possible with an indication of how these events affect, in the view of the Principal Investigator, the safety of the participants, and the continuation of the protocol.
• Are responsible for ascertaining and complying with all applicable legal and regulatory requirements with respect to consent and the protection of privacy of participants in the jurisdiction of the research project.

The Principal Investigator must:
• Ensure that the ethical guidelines and approvals of facilities or institutions involved in the research are obtained and filed with the REB prior to the initiation of any research protocols.
• Submit a Status Report to the REB upon completion of the project. If the research is a multi-year project, a status report must be submitted annually prior to the expiry date. Failure to submit an annual status report will lead to your study being suspended and potentially terminated.

The approval for this protocol terminates on the EXPIRY DATE, or the term of your appointment or employment at the University of Guelph whichever comes first.

Signature:                                      Date: April 8, 2015

L. Kuczenski
Chair, Research Ethic Board-General
Appendix B - Consent Form for Larger Project

Time 1 Guardian Consent Form

You are invited to participate in a follow-up interview as part of a research study you agreed to be involved in previously. The purpose of this ongoing study is to learn about how youth and their families are doing after receiving residential services like those at ________________ (insert name of agency). Being a part of this study will help to identify areas where youth and families are doing well after treatment. It will also help to identify areas in their lives where youth and families may be struggling and need more help.

The research study is being carried out by three professors. Two are from Wilfrid Laurier University. One is from the University of Guelph. Their names and numbers are on the last page of this form. Researchers hope to interview about 24 parents/guardians along with interviewing their child and mental health worker from six treatment centres in Ontario.

The follow-up interview is about 60-90 minutes long. The interviewer will ask you some general questions about how your child is doing currently, how things have changed since the first interview, and your hopes and expectations for your child in the coming year. The interviewer may also ask you some more detailed information about areas of your child’s life like family, friends, school, and behaviours.

Your participation in this study is completely voluntary. You can choose to withdraw from the study at any time. You can stop the interview at any time. You can choose to not answer any questions you do not want to. If you stop the interview before we are done, you can still let us use the information you have shared with us. If you would like to withdraw from the study at any time, you can contact the Research Director or Project Manager (using the information provided on the Contact Information Sheet) who will then remove your name and information from the study.

All information you share with the researcher will be kept confidential. The information will not be used to identify you or your family in any way. Your child and your child’s worker at __________ will not have access to any of the information you share with us. They will also not know whether or not you have agreed to be interviewed. Only the person who called you from __________ knows that you agreed to give your name to researchers to hear more about the study. That person has promised in writing to keep your name private (by signing a confidentiality agreement). __________ will not know you are in the study so any help you or your child may or may not receive from __________ in the future will not be affected by your participation in the study.

We would like to audio record the interview. You can choose not to have your interview audio recorded. Recordings and any other information will be kept in a secured location at the university (such as on a password protected computer in a locked private office). Only research
team members will have access to this information. Audio recordings will be kept for six months after your interview and paper files with no identifying information will be kept for seven years. All information will be destroyed after that.

Once we have talked to enough parents/guardians, youth, and workers we will write a report of what everyone said together. Nothing we write in our report will identify you or your family in any way. We may want to include quotes from parents in our report. If we do, we will make sure that it does not identify you or your family in any way. You are also protected by the fact that no one besides the research team knows that you are in the study. ______________ does not know whether or not you are in the study.

Any information you share in the interview will be kept confidential. However, if you tell me about any current mistreatment of children, by law I have to report this information to the Children’s Aid Society and in some situations a court of law could require us to disclose information by a subpoena.

Parents/guardians who are a part of the study will be contacted 2-3 times over the 12-18 months of the study to see how things are going for youth and their families. At each step, we will ask for your permission. After today, we would like to talk to you once more in about one year from now. At that time, we will ask you if you want to take part in another interview. If that is okay with you, we’d like to keep your name and information to contact you again. No one outside of the research team will see this information. Talking to parents/guardians and youth more than once will give us some information about how people’s lives can change over time.

Being interviewed may be helpful in letting you express your thoughts and feelings. But, if you find any of the questions upsetting and need someone to talk to, you can call any of the numbers on the last page. If you have any questions about the study, you can call us. Our number is on the last page.

Clearance for this study has been obtained from the Research Ethics Board at the University of Guelph. The results of our study will be posted on our web site. Copies of our reports will also be sent to various organizations providing services to families and children. Funding for this study is provided by the Social Sciences and Humanities Research Council of Canada.

You will receive a gift of $40 at each interview to thank you for your time.
Informed Consent

1. I have read and understand the information given to me. yes___ no___
   I have a copy of this form. I agree to be interviewed.

2. The interview can be audio recorded. yes___ no___

3. I allow the researchers to use quotes without identifying me. yes___ no___

4. I allow the researchers to keep my name on file to be contacted again.
   yes___ no___
   (Check all that apply) By phone___ By email___

5. I would like a written copy of the information I share today sent to me.
   yes___ no___
   (Check all that apply) By email____ By paper mail____

6. I would like to be sent information about the study’s overall findings and information on upcoming project workshops and conferences.
   yes___ no___
   (Check all that apply) By email _____ By paper mail____

_________________________________  ______________________
Parent/Guardian’s Signature            Date

_________________________________  ______________________
Interviewer’s Signature                Date
Contact Information Sheet

If you, or your child, need someone to talk to about your feelings, you can call:

Kids Help Phone (Up to age 20) 1-800-668-6868 Toll free
www.kidshelpphone.ca

London Distress Center and Suicide Hot Line (519) 667-6711

COAST Crisis Line 24 hr (Hamilton-Wentworth) (905) 972-8338

Canadian Mental Health Association (CMHA)

KW Distress Centre
Crisis Line/Mobile Crisis Team (519) 744-1813 or
www.cmhagrb.on.ca 1-866-366-4566 (Toll free)

CMHA London Office (519) 434-9191
London Mental Health Crisis Service (519) 433-2023 or
www.london.cmha.ca 1-866-933-2023 (Toll free)

CMHA Hamilton Office (905) 521-0090
www.cmhahamilton.ca

If you are looking for information on mental health, you can visit:
Children’s Mental Health Ontario

If you have any questions about the study, you can contact:

Dr. Michele Preyde, Research Director (519) 824-4120 ext. 58599
mpreyde@uoguelph.ca

Dr. Gary Cameron, Researcher (519) 884-0710 ext. 5240
camerongary@wlu.ca

Dr. Nancy Freymond, Researcher (519) 884-0710 ext. 5266
mpancer@wlu.ca

To access our research reports, you can call us or visit our web site www.wlu.ca/pcfproject.
If you have any questions about the way you were treated by researchers, you can contact:

Sandy Auld 519-824-4120 ext. 56606
Director, Research Ethics, University of Guelph
sauld@uoguelph.ca
Appendix C - Interview Protocol

Transition Experiences

• What was the first day like when the youth came home?
• How are things in your family since (youth name) left (agency name)?
• What was it like between you and (youth name) at first?
• What are some things you do and don’t like about (youth name) living at home now?
• How is your family doing now?
• What was it like between (youth name) and others in the home at first?
• How does (youth name) handle when things are not going well in the home?
• How are things going for (youth name) since leaving (agency name)?
• What did (youth name) find challenging?
• Was (youth name) mentally ready to leave?

Domains of Life

1) School and Work
2) Family Life
3) Peers and Community
4) Hopes and Dreams

For each domain of life, ask the following questions:

• How are things going for (youth name)?
• What is going well/not going so well?
• What are some things (youth name) likes or doesn’t like?
• How does (youth name) handle things they don’t like?
• What does (youth name) do when things don’t go well?
• What was it like in the first few days?
• How are things going now?
• How are things going with others (e.g. classmates, peers, other family members)?
**Personal Functioning/Coping**

- How is (youth name) doing emotionally and mentally now?
- How is (youth name) dealing with things?
- If (youth name) is feeling bad or having a hard time, what does s/he do to help her/himself?
- What makes (youth name) happy?
- What are some hobbies or things (youth name) is interested in?
- Who does (youth name) go to for help? How do they help?
- Is (youth name) able to do the things they need to in order to take care of her/himself?
- What does (youth name) need help with?
- Is (youth name) using any drugs or alcohol? If yes, why?

**General prompts or probes:**

- Can you tell me more?
- What was that like for you? For the youth?
- How did that feel for (youth name)?
- What is helpful? Not helpful?
- Can you give me an example?
### Appendix D - SDQ Score 4-Band Categorization

<table>
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<th></th>
<th>Close to Average</th>
<th>Slightly Raised</th>
<th>High</th>
<th>Very High</th>
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<tr>
<td>Emotional problems</td>
<td>0-3</td>
<td>4</td>
<td>5-6</td>
<td>7-10</td>
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<tr>
<td>Conduct problems</td>
<td>0-2</td>
<td>3</td>
<td>4-5</td>
<td>6-10</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>0-5</td>
<td>6-7</td>
<td>8</td>
<td>9-10</td>
</tr>
<tr>
<td>Peer problems</td>
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<td>Prosocial behaviour</td>
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<td>7</td>
<td>6</td>
<td>0-5</td>
</tr>
<tr>
<td>Total difficulties</td>
<td>0-13</td>
<td>14-16</td>
<td>17-19</td>
<td>20-40</td>
</tr>
</tbody>
</table>

*Note. Adapted from “Youthinmind. SDQ: Information for researchers and professionals about the strengths & difficulties questionnaires.” By Goodman (1997).*
Appendix E - Member Check Summary

Youth Transition Experiences

- Youth seemed happy to be home again
- Some youth were nervous or anxious
- Some youth had emotional swings or were sometimes impulsive
- Sometimes there was a lack of motivation
- Youth might feel overwhelmed or uncomfortable with the change

Parent Transition Experiences

- Many parents were often happy or excited to have their child home again
- Many parents felt overwhelmed with the change
- There was some worry about the future
- Some parents were relieved when their child returned home
- Parents sometimes struggled to trust their child

Youth Coping Strategies

- Many youth had activities to release emotions (e.g. painting or sports)
- When stressed, some youth spoke to family or friends for support
- Youth might avoid what is stressing them
- Youth might walk away if mad
- Youth might avoid social situations when stressed
- Some youth would use coping skills learned from RT

Support Networks

- Many parents provided support to their child
- Community supports were often used, such as schools or community groups
- Many parents expressed a lack of support
- Some parents felt a lack of support from the treatment centre