The Troubled Teen Industry:
Commodifying Disability and Capitalizing on Fear

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B.A. in English, May 2015, The George Washington University

A Thesis submitted to

The Faculty of
The Columbian College of Arts and Sciences
of The George Washington University
in partial fulfillment of the requirements
for the degree of Master of Arts

May 21, 2017

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Acknowledgements

The author wishes to acknowledge all of the faculty members in the English Department at the George Washington University who have supported her in the process of this endeavor, including Professor Marshall Alcorn, Professor Robert McRuer, Professor Evelyn Schreiber, and Professor David Mitchell, as well as operations director Constance Kibler. Furthermore, she thanks all of the brave former residents of this industry who have collaborated with her in this research, especially Rachael McAllister and Mollie Halper. This work could not have been done without the documentation and reportage of the independently motivated journalists and public figures who have worked tirelessly to bring this issue to light, most notably journalist Maia Szalavitz and Congressman Adam Schiff.

Abstract of Thesis

Troubled Teen Industry:
Commodifying Disability and Capitalizing on Fear

The “Troubled Teen” behavior reform industry is comprised of financially interconnected wilderness programs, residential treatment centers, and reform schools that incarcerate thousands of minors each year by marketing a supposed cure to non-normativity, and monetizing the discrimination and abuse of children with a myriad of disabilities, including mental illness, substance abuse and dependence, eating disorders, cognitive difference, or who simply exhibit subjectively “negative”- in the parents’ eyes- traits or habits, such as LGBT status or genuinely problematic behaviors that make them difficult to parent. These programs claim to treat or change teenager behavior that parents find troubling via “tough love” behavior modification, which has generated a wide spectrum of existing criticism documenting the abuse and neglect of teenagers that is endemic to its nature and mode of treatment, one predicated on discriminatory principles that stigmatize and condemn facets of non-normativity. Justifying this maltreatment with quasi-psychological terminology and bastardized clinical practices makes a mockery of mental healthcare, and promotes the idea of othering persons who do not conform to normative ideas of “acceptable” behavior and cognition. Congressional hearings, Governmental Accountability Office reports, and prolifically documented individual testimonies and lawsuits related to abuse and wrongful death have culminated in currently proposed federal legislation in Senate Bill 3031. Nonetheless, this industry continues to flourish with massive profit margins. In the meantime, it is crucial to define a system of ethics for staff that work within any institution for legal minors, legitimate or

not, that is predicated on cultivating dependency and removing basic autonomy as part of their program or treatment, whether or not the child's "condition" is one that involves inherent dependency. These institutions render patients disabled due to the very environment in which they are placed, a theory championed by Tom Shakespeare. This thesis aims to use trauma and disability theory, analysis of aesthetic representations of incarcerated "troubled teens," and objective research to delimit and critique this corporate industry by exposing tits market pitch and corporate culture, the deforming principles on which it functions, and the deliberate treatment model in place that characteristically abuses the people, both parents and children, to whom it caters, tracing the roots of this industry back to American Eugenics, and exposing the obfuscated system of privatized incarceration that has stolen the wellbeing and even the lives of the most vulnerable minors.

Table of Contents

List of Figures

List of Tables

Defining the Troubled Teen Industry and its Corporate Practices

Introduction

The "Troubled Teen" behavior reform industry, which includes wilderness programs, residential treatment centers, and reform schools, preys on vulnerable youth and desperate parents by simultaneously creating a demand for its services through sensationalized fear mongering about the future of at-risk youth who it solicits for placement within facilities. This industry has come under heavy criticism from many fronts. Congressional hearings, Governmental Accountability Office reports, and prolifically documented individual testimonies and lawsuits have culminated in currently proposed federal legislation. Existing criticism of this industry documents the abuse and neglect of teenagers that is endemic to its nature and mode of treatment. Nonetheless, this industry continues to flourish with massive profit margins, despite the widespread abuse and neglect specific to this brand of establishments. This paper explores the nature of the industry, its market pitch and corporate culture, and the nature of treatment delivery that characteristically abuses the people, both parents and children, to whom it caters.

Defining the "Troubled Teen Industry",

This industry works in relation to a variety of programs to that claim to treat or change teenager behavior that parents find troubling. There is little professional supervision of either the criteria for defining a "troubled teen" or the selection of staff that allegedly treat the adolescents in their care. Many programs mimic legitimate facilities or experiences: wilderness programs market themselves like outward bound- type outdoor healing adventures. Residential treatment centers are marketed as anything from "therapeutic" boarding schools to inpatient-psych wards, despite failing to offer the

properties of either function. For the purpose of this paper, I will define the "Troubled Teen Industry" in accordance with the targeted "covered programs" in Senate Bill S.3031: Stop Child Abuse in Residential Programs for Teens Act of 2016.

> "each facility of a program operated by a private entity that, with respect to one or more children who are unrelated to the owner or operator of the program, purports to provide treatment or modify behaviors in a residential environment, such as—(i) a program with a wilderness or outdoor experience, expedition, or intervention; (ii) a boot camp experience or other experience designed to simulate characteristics of basic military training or correctional regimes; (iii) a therapeutic boarding school; or (iv) a behavioral modification program."

This is exactly the type of legislation that would comply with the United Nations Convention on the Rights of Children, which suggests that "(1) juveniles are treated as individuals and guaranteed rights to due process (like that for adults) with impartial authorities and legal representation in matters of psychiatric institutionalization; (2) psychiatric facilities, both state-run and private-run, are subject to periodic reviews of both the treatment provided to juveniles and of all other circumstances of juvenile placement; and (3) appropriate action is taken to correct any violations found during the reviews." (Molnar 99). The United States is one of the few Western countries who have yet to enact similar protections for children.

The Alliance for the Safe, Therapeutic and Appropriate Use of Residential Treatment has compiled useful material that explicates the links between seemingly disparate pieces of this lucrative puzzle. "The wilderness programs and therapeutic boarding schools that market to parents of "troubled teens" may seem like small, locally-owned, well-regulated nonprofits. But the truth is, with few exceptions, these are lightly-regulated for-profit businesses owned and operated by large corporations." It is clear that the purpose of this industry is not to offer useful services to the community and to

struggling adolescents, but rather to make money from uncritical parents and suffering teens with a stratified, financially linked progression from initial consultation, to short-term “intervention” wilderness programs, to long-term residential centers. The advertising of such programs usually begins with marketing a short-stay intensive wilderness program that lasts up to 6 weeks; however, due to the financial affiliation of these wilderness programs and long-term residential treatment centers, about 40-45% of children enrolled in short-stay wilderness programs end up in long-term residential treatment centers or therapeutic boarding schools (CAICA.org). By marketing the programs as short-term, parents are more easily manipulated into sending their children into the grasp of the industry. Once there, it is far easier to pressure parents into committing to a lengthy stay in an affiliated facility using the threat of relapse or exacerbation of causal problems if the child returns home. Once their child is detained in such an institution, the parents are continuously warned that their child will die or relapse into old behaviors if they do not complete the program.

The National Association of Therapeutic Schools and Programs, NATSAP, “serves as an advocate and resource for innovative organizations which devote themselves to society’s need for the effective care and education of struggling young people and their families” and has 181 affiliate members. Although membership is usually suggested to insinuate accreditation, this organization instead functions as an advocacy group for program and officials. Their publication, The Journal of Therapeutic Schools and Programs (JTSP), “has the goal of prodding the NATSAP membership to think more deeply about our profession. We support all employees of NATSAP programs in their continuing development toward becoming more thoughtful, reflective

practitioners who contribute to improving our work with children and families. We encourage and welcome empirical research in the JTSP, and we also encourage thoughtful reviews, clinical case studies, and considerations of education, recreation, program, risk management, and program management as well." As a resource not for parents or teenagers, but instead for the benefit of program officials, the research articles included within this publication reveal many deforming principles of how these institutions operate by highlighting the true goals of their practices. The 2008 edition includes an article entitled "Current Descriptions of National Association of Therapeutic Schools and Programs (NATSAP) Members" which provides crucial insight to both the scope and demographics of residents "served," and how they are placed in these facilities.

> "NATSAP programs participating in the study reported they served 8,86 individual clients or students a year. Furthermore, when comparing the total reported average daily census for the past year (3,857) with the sum of the reported maximum enrollment figures (5, 2), it can be estimated that the average program in the sample was operating at approximately 75% capacity. Assuming that the sample is representative of the total NATSAP membership, it can be estimated that the entire NATSAP membership served over 7,726 students/clients a year and has the capacity to serve 23,630 clients a year" (Young and Gass, 168).

Table 5. Treated and Non-Treated Diagnoses for Surveyed NATSAP Programs.

Diagnosis/problem	% of programs in sample identifying this diagnosis/ problem as something their program can directly address	% of programs in sample that exclude from admission clients/students with the diagnosis/problem
Abuse (physical or sexual)	91%	3%
Adjustment Disorders	83%	2%
Antisocial Behavior/Conduct Disorder	48%	39%
Anxiety Disorders	93%	2%
Attachment Disorder	85%	29%
Aspergers Disorder	53%	5%
Attention Deficit/Hyperactivity Disorders	95%	3%
Autistic Disorders	9%	66%
Bi-polar Disorder	87%	8%
Conduct Disorder	38%	40%
Depression	97%	3%
Dissociative Disorders	31%	37%
Eating Disorders	41%	37%
Impulse Control Disorders (Explosive, Kleptomania, Pyromania, Hair pulling)	46%	37%
Learning Disorders (including mental retardation)	53%	24%
Oppositional Defiant Disorder	91%	5%
Parent-Child Relational Problem (including Adoption)	93%	3%
Personality Disorders	53%	17%
Schizophrenia and other Psychotic Disorders	10%	74%
Sexual Offense	9%	78%
Sleep Disorders	25%	30%
Somatoform or Factitious Disorders	23%	32%
Substance Addictions or Related Disorder	82%	14%
Tic Disorder	26%	23%
Tourette's Disorder	32%	31%
Trauma Including PTSD	77%	5%

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1. Severe emotional disturbance – clinical depression, post-traumatic stress disorder, mood disorders, attachment disorder, and self-destructive behaviors.

2. Aggressive/violent behavior – oppositional & de ant behaviors, conduct disorder, assault, and other forms of physical aggression including self-injurious behavior.

3. Family/school/community problems – inability to function at home, in school, or in the community; family dysfunction, placement failures, needing an alternative to juvenile justice and drug use/abuse

4. Abuse – physical, sexual, or emotional abuse.

Admissions Criteria as Marketing- Manufacturing Demand

This is a market in which unregulated facilities are given control of impressionable adolescents who are either marked categorically as "bad" due to behavioral or lifestyle complaints by their parents, or demonstrate more serious impairments like substance abuse, eating disorders, and mental illness. As a result, institutions pry on these parents' desire for treatment. Sometimes, the Internet is the only resource used to determine a parent's need or desire to place their child in such a facility. A simple online Google search for "troubled teen" brings up myriad websites that, while appearing to be resources, are actually advertisements for expensive programs. These centers pathologize common teenage behavior and frequently assess a child's needs using nothing more than a questionnaire on the program's web page, then emphatically recommend immediate enrollment in their program. Unlike the U.S. prison system and legal psychiatric wards, no medical diagnosis or due process of law is required before enrollment. Troubled Teen treatment centers cater to parents' desire for radically life-altering treatment that will change their teenage child's behavior. Lumping hugely different issues together in their questionnaires for admittance, such as "Does your child slam doors, throw objects, destroy property out of anger, or use intimidation to get his/her way?", children are sent to such institutions for reasons ranging from "poor choice of friends" to "drug and alcohol addiction or trouble with the law" (Teen Revitalization). Yet, despite the glowing reviews proudly posted by treatment centers on their websites, the efficacy of tough love behavior modification is unsubstantiated due to a lack of

follow-up after patients are released. The only easily accessible results are filtered through and propagated by the institutions themselves, and thus are neither reliable nor objective assessments of the long-lasting effects of these programs.

Solicitation Techniques

When parents use in-person resources, educational consultants are often the first step in the solicitation into long term stay: "Approximately 25-40 percent of placement referrals appear to come through educational consultants, people who are paid to assist students and families with educational decision- making […] who may be receiving a financial or non-cash incentive to place your child in the program." Educational consultants generally recommend a short-stay wilderness program, lasting 1-2 months, and then emphatically recommend placement in a long-term facility. Three investigative reports by the Government Accountability Office (GAO) by Greg Kurtz and Kay Brown from 2007-2009 found these financial links, and the Federal Trade commission issued a warning statement in 2009 for parents to beware of these marketing practices:

> "Posing as fictitious parents with fictitious troubled teenagers, GAO found examples of deceptive marketing and questionable practices in certain industry programs and services. For example, one Montana boarding school told GAO's fictitious parents that their child must apply using an application form before they are admitted. But after a separate call, a program representative e-mailed an acceptance letter for GAO's fictitious child even though an application was never submitted. In another example, the Web site for one referral service states: "We will look at your special situation and help you select the best school for your teen with individual attention." However, GAO called this service three times using three different scenarios related to different fictitious children, and each time the referral agent recommended a Missouri boot camp. Investigative work revealed that the owner of the referral service is married to the owner of the boot camp."

This is not an isolated incident: A demographic study published in JTSP notes "that educational consultants were a major source of referrals for NATSAP programs, which "received more than 90% of their referrals from educational consultants. This was

particularly noteworthy considering none of the other seven referral sources (i.e., clinical professionals, 3rd party payers, internet, NATSAP directory/ website, previous clients/families, "other" advertising, other programs) made up more than 85% of any program's total […]" (Young and Gass, 171)

For "admission criteria," which essentially creates the supposed need and demand for services, programs frequently assess a child's needs using nothing more than a questionnaire on the program's web page, and then emphatically recommend immediate enrollment in their program. The Teen Help LLC admissions survey, which appears on most programs' websites I reviewed, reads as an amalgamation of a medical questionnaire, mental health screening, and a forum for parental grievances. Questions range from the degree to which one's child" Sulks, pouts, or cries (33)" or "has friends of whom I don't approve (37)," to how often said child "Thinks about suicide, says s/he would be better if s/he were dead (41)," and "Sees, hears, or believes things that are not real (20)." For example, the first google result a parent might find upon searching for an answer to their wayward progeny, "troubledteen.com," opens with the very bold statement, "troubled teens destroy families' lives" followed by a series of links to "click here today" or "request more information online" about boarding schools, boot camps, wilderness programs, and residential treatment centers. These bolded links redirect to "Parent Help LLC," which has three tabs: "take control" "find a program" and "get financing," which not only insinuates that the only way to take control is to find a program, but also reveals the main priority- financing hugely expensive stays. The lumping together of clinically or legally significant issues and conditions with difficult or irritating behaviors born of hormonal changes inherent to puberty is detrimental to

children. This negative assessment encourages maltreatment and enables staff to use the premise of “tough love” to “break down” children and instill rule compliance with impunity. This systemic abuse is both shrouded and shielded because these so-called medical “professionals” who work in centers designed to supposedly fix or save “bad kids” are trusted over any adolescents who have the courage to bring forth claims of abuse and neglect.

Discovery Ranch, a treatment center located in Mapleton, Utah, provides an empirical example of how this industry rhetorically manipulates legitimate psychiatric conditions to solicit clients. Their website lists the following conditions the program claims to treat: various mental illnesses including “anxiety, depression, mood disorders, ADHD, and oppositional defiance”[1]— the last of which is no longer listed in the DSM— “substance abuse and other addictions, eating disorders […] learning disorders and nonverbal learning disability […] social struggles, low self-esteem, adoption/attachment issues, and grief and loss”[2]. The unadvertised conditions that I witnessed among detainees included being LGBT, “Internet addiction”, and one girl in particular was sent there for having a black boyfriend. Aside from the obvious prejudice and discrimination, many of these “conditions” are not legitimate clinical impairments, and those that are require individualized care, which this facility does not provide.

Pseudoscience and Misinformation

Sometimes, the red flags about the true nature of troubled teen treatment centers are hidden in plain sight, yet are overlooked due to the intense pressure that is conveyed

[1] FAQ." *Discovery Ranch Teen Residential Treatment Center for Boys*. Redcliff Ascent.
[2] ibid

to immediately enroll one's child, and the false sense of security and relief that placement cultivates. Websites for treatment centers are aesthetically pleasing and often seem legitimate, yet fall apart upon closer inspection. For example, Second Nature Wilderness Program describes their therapeutic model as "clinic ally sophisticated," yet in the treatment section, describes only the experience of camping and accountability, making source less claims like "The use of metaphor is recognized as the most effective means of bypassing an adolescent's natural resistance and defenses in therapy." The selling point of this therapy is not focused on the child's perspective, but rather catered to parents' difficulties with said children.

The Discovery Ranch website also includes a page of links to educational articles, which universally include faulty information about teenage "problems." The rhetoric is misleading and used deceptively to deceptively manipulate parents into placing their children in the care of Discovery Ranch. Such rhetoric is derived mostly from illogical research and scare mongering claims. The primary example of this fraudulent parental education takes place in the article entitled How to Drug Test Your Teen. Written in a casual, colloquial tone, with gender-specific pronouns that presume drug users to be solely males, the article is completely devoid of references, let alone substantiated facts. The following excerpt elucidates how quasi-educational, flatly fake "research" is used to make parents feel hopeless and afraid for their child's wellbeing, and vulnerable to the idea of sending their child to Discovery Ranch:

> Let's look at how this might work. Say that a parent drug-tests a teen every Monday, via a urine sample. Prior to the test, Informed Teen Drug User judiciously abstains. However, right after the test, he starts up again. He knows he can smoke pot that night, and then snort methamphetamine, pop OxyContin and Vicodin, smoke crack cocaine, inject heroin, and stay drunk every day for the next four days. At that point, he temporarily stops using the drugs, but

continues to stay drunk until 12 hours before the following Monday's test.
Result: He tests clean, and starts the drinking and drugging cycle all over again. [3]

A rudimentary understanding of how drugs and alcohol function in the human body points to the absurdity and falsity of this assertion. Needless to say, any person who simultaneously ingested marijuana, methamphetamines, multiple opiates, crack cocaine, heroin, and alcohol would overdose and most likely die, and most certainly would test positive for drug use if drug tested the very next day. A parent of an "at-risk" teenager, however— especially one who is already considering out-of-home placement— is significantly more likely to be swayed by this false assertion than any objective reader would be. Yet without qualms, Discovery Ranch uses seemingly objective educational articles, none of which are remotely legitimate, to increase fear and vulnerability in their prospective clients, and to demonize the children it solicits for treatment. This attitude of such dehumanizing condemnation is extremely foreboding considering the treatment these children are subjected to once under their care.

Discovery Ranch's literature includes an educational article entitled Disclosure of Extramarital Sexual Activities by Persons With Addictive or Compulsive Sexual Disorders: Results of a Study and Implications for Therapists. The opening line of this article begins **"**Despite religious and cultural precepts that forbid sexual activities outside marital relationships, such behaviors have continued in most societies and are common in the United States." As a treatment center for minors, adultery would presumably not be an issue for which children would need to seek treatment. The moral attitude of this article, that extramarital sex constitutes sex addiction, indicates the blurred line between

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[3] Fritzlan, Larry. "How to Drug Test Your Teen." *Discovery Ranch Teen Residential Treatment Center for Boys*. Adolescent Recovery Services, 2007.

religious beliefs and psychological care that occurs frequently within the industry as a whole.

One of the primary qualifications necessitating treatment that Discovery Ranch uses to solicit clients is substance abuse. The first article posted on the list of educational resources for parents is a description of "Alcohol Use Disorder" by John L Miller, MD, in the section entitled "Alcoholism." In comparison to the diagnostic criteria found in the DSM-IV, the classification of alcohol use disorder is misinterpreted and manipulated to classify any use of alcohol as pathological and clinically significant. Miller commences his anti-drinking tirade with the following statement: "Alcohol Use Disorders include alcohol dependence, alcohol abuse, alcohol intoxication, and alcohol withdrawal."[4] This statement adds "alcohol intoxication" and "alcohol withdrawal" to the two subcategories found in the DSM-IV under "alcohol use disorder." Rather than a categorical umbrella term that is subdivided to specify problematic drinking behavior, the term "Alcohol Use Disorder" is manipulated into a freestanding term to condemn drinking any alcohol at all. The negative effects that theoretically serve as diagnostic criteria for alcohol dependence and abuse listed by Miller include the following:

> Alcohol intoxication often causes a person to experience emotional changes such as moodiness or irritability. The person may also experience such physical changes as slurred speech and poor coordination. Excessive alcohol use may lead to memory loss called "blackouts."

By contrast, the DSM-IV, the edition to which Miller presumably refers, without directly

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[4] Miller, John L., MD. "Alcohol Use Disorder." *Discovery Ranch Teen Residential Treatment Center for Boys*. July 2000.

citing any sources, defines solely alcohol abuse and dependency, listing specific criteria that do not include those specified by Miller:

Alcohol Abuse:

(A) A maladaptive pattern of drinking, leading to clinically significant impairment or distress, as manifested by at least one of the following occurring within a 12-month period:

- Recurrent use of alcohol resulting in a failure to fulfill major role obligations at work, school, or home
- Recurrent alcohol use in situations in which it is physically hazardous
- Recurrent alcohol-related legal problems

Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol

Alcohol Dependence:

- Need for markedly increased amounts of alcohol to achieve intoxication or desired effect; or markedly diminished effect with continued use of the same amount of alcohol
- The characteristic withdrawal syndrome for alcohol; or drinking (or using a closely related substance) to relieve or avoid withdrawal symptoms
- Drinking in larger amounts or over a longer period than intended.
- Persistent desire or one or more unsuccessful efforts to cut down or control drinking
- Important social, occupational, or recreational activities given up or reduced because of drinking
- A great deal of time spent in activities necessary to obtain, to use, or to recover from the effects of drinking.

Corporate Culture and Profit Margins

ASTART crunches the numbers of "the two corporations that dominate the "troubled teen" industry:

> CRC Health Group, Inc., a global multinational corporation, owns and operates Aspen Education Group, and 27 of the largest residential programs for teens. In the first six months of 2011, CRC Health reported revenue from youth residential programs of $27.6 million, and from youth outdoor behavioral programs of $13.5 million—total revenue of $41.1 million. The average length of stay was up 18.1-19.5%. Outdoor programs, however, are far more profitable. In the first six months of 2011, CRC Health Group reported net revenue at residential programs of $369.04 profit per youth per day, while outdoor programs brought in net revenue of $541.42 profit per youth per day.
>
> Universal Health Services, Inc. is a Fortune 500 company that operates more than 200 behavioral health facilities in 37 states, Puerto Rico and Virgin Islands, including

residential programs for youth and juvenile detention centers. In 2010, the behavioral health facilities produced revenues of $1.3 billion, and net profits of $252 million."

Members of NATSAP were assessed to find the median cost per day, shown in the table below:

	Emotional Growth Boarding School	Outdoor/ Wilderness	Residential Treatment	Therapeutic boarding School	Transitional Living	Young Adult
Average Cost per day	$165	$332	$318	$216	$181	$223
Minimum fee charged	$134	$115	$125	$158	$110	$115
Maximum Fee charged	$197	$495	$700	$370	$263	$495

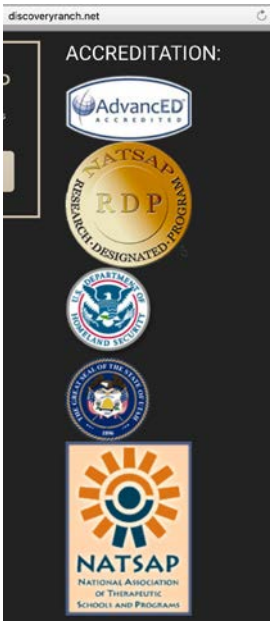
(Young and Gass 178)

Discovery Ranch is a prime example of how corporate holdings financially exploit parents out of hundreds of thousands of dollars. Discovery Ranch Holdings LLC shares not only an address, but also a specific suite with its parent company, RedCliff Ascent, which according to Dun & Bradstreet makes an annual profit of $910,000. Additionally, an apparently distinct entity, Ascent Inc. also shares not only this same location, but also Jim Salisbury as CEO and board member. Ascent, Inc. grosses 6.94 million, and is categorized by industry as "NAICS 1: All other outpatient centers" and "SIC 1: rehabilitation and outpatient centers." Redcliff Ascent, however, bears the industry category of "SIC 2: Respiratory Therapy Clinic" and "SIC 1: Meditation Therapy." On RedCliff Ascent's official website, however, there is absolutely no indication that any services their wilderness programs or residential treatment centers provide involve "meditation or respiratory therapy" at all. This categorization, which does not match the services indicated through marketing materials, also conveniently entails less scrutiny and oversight than a rehabilitation clinic might.

Discovery Ranch's program costs $11,500 a month. According to the website, " [the] [l]ength of stay varies for each student, depending on their therapeutic progress. Some students have reached our highest level in 7 months and some have taken nearly 2 years. When we crunched the numbers, the average stay is 8-10 months."[5] This "average" 8-10 month stay thus costs between $92,000 and $115,000. "Teen Help LLC," is the marketing arm of the newest incarnation of the World Wide Association of Specialty Programs, WWASP. This was the largest and best known umbrella organization that "is linked with a series of interconnected limited liability corporations over which true ownership is unclear but which include the same cast of leading characters" (Szalavitz, 220). Dane Kay, listed on the Discovery Ranch Board of Directors, is the brother of Ken Kay, president of what was formerly known as WWASP. Despite WWASP's official disbanding, the Troubled Teen Industry continues to profit and thrive under ever-shifting renaming and rebranding strategies. Discovery Ranch, like most peer institutions, avoids regulation by paying dues to an affiliate Program Trade Organization, the National Association of Therapeutic Schools and Programs that "[does] not properly monitor or set specific standards of care to ensure the safety and wellbeing of all students… Membership status does not depend on proof of standards being met, the only requirement is payment of dues."[6]

[5] "FAQ." *Discovery Ranch Teen Residential Treatment Center for Boys*. Redcliff Ascent.
[6] Alliance for the Safe, Therapeutic & Appropriate Use of Residential Treatment." *Stop Abuse in Residential Treatment for Troubled Teens*. Troubled Teen Industry: Help or Harm? 16 Mar. 2015.

Even though NATSAP is decidedly not a regulatory body, Discovery Ranch's membership is staged as an indication of meeting state and federal regulations:



Program Type	Percentage of programs accredited by AEE	Percentage of programs accredited by CARF	Percentage of programs accredited by COA	Percentage of programs accredited by JCAHO
Emotional growth Boarding School	0%	0%	0%	0%
Home-based/Small Residential	0%	0%	0%	0%
Outdoor/ Wilderness	19%	13%	13%	13%
Residential Treatment Center	3%	0%	0%	38%
Therapeutic Boarding School	9%	0%	5%	9%
Transitional/ Independent Living	20%	0%	0%	0%
Young Adult	0%	0%	0%	0%
All Program Types Combined	8%	2%	4%	18%

Table 7 summarizes the different types of state licensure (or lack of licensure) possessed by programs in the NATSAP sample, which reveals the following pattern: "It appears that The Joint Commission (JCAHO) may offer the accreditation that was sought by the most number of NATSAP Member programs, but it is clear that accreditation of any sort was by no means the norm. Of the 85 programs in the 2007 AACRC Membership Directory that reported accreditation information, 49% possessed Council on Accreditation (COA) accreditation, % held JCAHO accreditation, and 27% possessed accreditation from some other organization (8 % of this last group, however, were accredited by COA or JCAHO as well)." (Young and Gass 179)

Education

While the websites often claim that children receive educational services with private tutors catering to their every need, most these institutions simply tear out chapters of textbooks and assign them to their detainees, while a "teacher" who often has only a high school education supervises the classroom of up to 50 students in completely different grades and courses. The children are given torn-out chapters from textbooks with a study guide, instructed to silently learn this segmented material with minimal instruction, and then take tests on these chapters until they score an 80% or higher, essentially encouraging them to memorize the questions and answers until they achieve a passing grade (CAFETY.org). This "teaching style" encourages rote memorization rather than the acquisition of knowledge. Thus, with students receiving these artificially inflated grades, the programs can market unrealistically high educational success rates to potential clients, while obscuring how these grades are attained.

Staff Qualifications

Few, if any, program officials have the credentials to run facilities for these children, as seen in the extensive investigative reports into various program staff by Angela Smith, Patrick Leiberg, and Tim Brown of HEAL-online.org. Heal-online.org is a comprehensive website promoting the Teen Liberty Campaign. In the pursuit of its primary mission, to combat the troubled teen industry, one of the efforts made by this organization includes a comprehensive look at the background qualifications of staff in various treatment centers. Clinton Dorney's bio on the Discovery Ranch website reads as follows:

> At a very young age Clinton realized that he could have an impact on others' lives through service and being involved. He is happiest when he is making a

> difference in others' lives. Clinton is married and has four children. He loves spending time with them doing just about anything. They are his life. Clinton uses the same principles that they teach at the Ranch at home with his kids. It works. Clinton fell into this industry because his brothers have worked in other Residential Treatment Centers. He started out his career in admissions. He loves his work and feels blessed to have found something that he loves to do and get paid to do it. Discovery Ranch has been a passion for him in that he gets to help create experiences for others the way his parents did for him when he was young.[7]

None of this anecdotal, feel-good sentiment translates to an ability to effectively run a treatment center, nor does this brief bio include any professional qualifications. The entirety of HEAL's investigative findings about lack of Discovery Ranch staff credentials is included below:

Name	Unit/Position	Additional Information
Clinton Dorny	Executive Director	Siblings work at other residential programs. **Dorny is not a licensed mental health nor medical professional in Utah. Source:** https://secure.utah.gov/llv/search/index.html
Leslie Giles	Residential Director	Giles has worked in the industry for over 20 years. **Giles is not a licensed mental health nor medical professional in Utah. Source:** https://secure.utah.gov/llv/search/index.html
Victoria Fielding	Academic Director	BYU graduate. HEAL is in the process of determining whether or not Fielding is a licensed educator in Utah. We will post the information as soon as it is available.
Marlene Kendall	Admissions	**Kendall is not a licensed mental health nor medical professional in Utah. Source:** https://secure.utah.gov/llv/search/index.html
Matt Child	Therapist	**Child is not a licensed mental health nor medical professional in Utah. Source:** https://secure.utah.gov/llv/search/index.html
Terri Miller	Boys Program Supervisor	Works on the "Forget About Me" program within Discovery. **Miller is not a licensed mental health nor medical professional in Utah. Source:** https://secure.utah.gov/llv/search/index.html
Brock Burrows	Girls Program Supervisor	Student at BYU. **Burrows appears to no longer work at this program. Burrows is not a licensed mental health nor medical professional in Utah. Source:** https://secure.utah.gov/llv/search/index.html
Jerry Christensen	Exper. Director	**Christensen is not a licensed mental health nor medical professional in Utah. Source:** https://secure.utah.gov/llv/search/index.html
Jake Thorson	Coordinator	Thorson formerly worked at other unnamed wilderness and residential programs.* **Thorson is not a licensed mental health nor medical professional in Utah. Source:** https://secure.utah.gov/llv/search/index.html
Jennifer Charrier	Admissions	**Charrier is not a licensed mental health nor medical professional in Utah. Source:** https://secure.utah.gov/llv/search/index.html
Dan Miner	Calf Program Manager/Mentor	**Miner is not a licensed mental health nor medical professional in Utah. Source:** https://secure.utah.gov/llv/search/index.html
William Perry Garso	Therapist	Garso earned his MS at the University of Phoenix. Source: https://secure.utah.gov/llv/search/index.html The University of Phoenix does not have the specialized accreditation necessary for degrees in psychology. (Source: http://ope.ed.gov/accreditation/Search.aspx)
Shelly Thomas	N. Program Coord.	**Thomas holds no professional licenses in Utah. Thomas is not a licensed mental health professional, counselor, social worker, therapist, nor social worker. Source:**https://secure.utah.gov/llv/search/index.html
Dane Kay	Board of Directors	**Kay holds no professional licenses in Utah. Kay is not a licensed mental health professional, counselor, social worker, therapist, nor social worker. Source:**https://secure.utah.gov/llv/search/index.html **In addition, Kay comes from the Kay Family involved with WWASPS family of fraudulent and abusive programs.**

It is crucial to note that these above findings reflect only upon the corporate, high-level staff; none of the "mentors" with whom students interact for up to 10 hours a day

[7] "Clinton Dorny." *Discovery Ranch Teen Residential Treatment Center for Boys*.

are listed anywhere. The "clinically sophisticated environment" that Discovery Ranch and other similar programs purport to maintain implies that staff are clinically trained and certified. A study included in JTSP that examines an attempted mitigation of negative impacts for direct care staff elucidates this ratio of contact between professionals and children, and "para-professionals":

> "The irony for those of us providing residential treatment for children is that the very staff who have the most contact and often deepest relationships with youth are those with the least amount of training and time for improving their therapeutic alliances – direct care staff. […] In order to provide an opportunity to enhance self-reflection in the very important work of providing care for the "other 23 hours" (Fahlberg, 1990) outside of the one hour of weekly therapy, a children's residential program in the western United States has created […] "Family-Team Dynamics" or FTD" (Kohlstaedt 22).

The residential staff in question, whom I observed and who job review sites like indeed.com indicate were and are usually hired 20 at a time with an extremely high turnover rate, are paid an overnight shift hourly wage of $9 according to Glassdoor, and a recent Indeed job posting lists the following solely subjective qualifications: "Exceptional relationship skills, Dependable, Demonstrate the ability to hold appropriate boundaries and distributing consequences as appropriate, previous work with mentoring or youth preferred, [and] Must be 21 years or older to apply." The operating costs are extremely low, as children are underfed, often with food withheld as punishment, and do all the manual labor to work the profitable functioning ranch and maintain the facility. At Discovery Ranch, there were a total of six therapists for all the students in question, while the typical number of minimum-wage daily staff numbered in the 40 to 50's, including the night watch staff.

The same study by Young and Gass includes a "Table [that] summarizes the average salaries paid at programs in the sample for each type of position and academic level listed.

Numbers Employed

> Approximately 77 of the NATSAP programs in the sample responded to questions asking for the numbers of staff employed. For full time staff, programs employed between 2 and 50 staff members, with a mean of 47 full time employees per program. The range for part time and seasonal employees was 0 to 00, with a mean of part time employees and 5 seasonal staff. Total staff employed by the reporting programs was 4882 employees (654 full time, 990 part-time, and 238 seasonal). (Young and Gass 174)

The noted admissions staff, whose positions consist of marketing, PR, and parent contact, are paid more than twice the salaries of the child care workers and night shift staff, despite interacting with students only upon admittance versus around the clock. Therapists typically meet with students just once a week and make the highest salaries listed. Thus, the astronomical profits are skewed largely in favor of a minority of staff members, all of whom have the least direct impact on a student's therapeutic process and general daily wellbeing.

Treatment Model and Documentation of Its Abusive Nature

Why is this a problem, and why is this federal legislation being proposed? Congressional hearings have called for an examination of these programs because of the widespread allegations and documentation that shows the fraudulent nature of this industry, and the rampant abuse within it. In the most recent iteration of the 3 previously proposed Stop Child Abuse in Residential Programs for Teen Act, the proposed regulations and prohibitions in the "minimum standards" reveal the current state of operating practices that are widespread enough to necessitate federal regulation. Consider the following three clauses:

> (B) PROHIBITION ON CERTAIN DISCIPLINARY TECHNIQUES. — Disciplinary techniques or other practices that involve the withholding of essential food, water, clothing, shelter, or medical care necessary to maintain physical health, mental health, and general safety, shall be prohibited.

(C) PROHIBITION ON PHYSICAL OR MENTAL ABUSE. —Acts of physical or mental abuse designed to humiliate, degrade, or undermine a child's self-respect shall be prohibited.
(D) LIMITATION ON RESTRAINTS AND SECLUSION. —
(i) The use of seclusion, mechanical restraints, and physical restraints that impair breathing or communication is prohibited.

The disciplinary techniques referenced above are often used to force confessions of misdeeds, real or imagined, from teenagers in these facilities. The information obtained is then used as a basis for further punishment or extended stays. This dynamic explicitly violates not only U.S. constitutional prohibitions on cruel and unusual punishment, but also the Geneva convention on torture, as defined in Article 1:

> For the purposes of this Convention, torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.

Although this international prohibition on the violation of human rights was initially staged in terms of armed conflict, the Red Cross notes the extension of its applicability to persons who are not acting as state officials:

> In its subsequent case-law in the Kunarac case in 2001n […] the Tribunal held that "the presence of a state official or of any other authority-wielding person in the torture process is not necessary for the offence to be regarded as torture under international humanitarian law". It defined torture as the intentional infliction, by act or omission, of severe pain or suffering, whether physical or mental, in order to obtain information or a confession, or to punish, intimidate or coerce the victim or a third person, or to discriminate on any ground, against the victim or a third person.[20]

The abuse widely documented within troubled teen treatment centers also fits the bill for inhuman treatment:

> The term "inhuman treatment" is defined in the Elements of Crimes for the International Criminal Court as the infliction of "severe physical or mental pain or suffering".[22] The element that distinguishes inhuman treatment from torture is the absence of the requirement that the treatment be inflicted for a specific purpose […] stressing the severity of the physical or mental pain or suffering. They have found violations of the prohibition of inhuman treatment

> in cases of active maltreatment but also in cases of very poor conditions of detention,[25] as well as in cases of solitary confinement.[26] Lack of adequate food, water or medical treatment for detained persons has also been found to amount to inhuman treatment.[27]

In a testimony before the Committee on Education and Labor, House of Representatives, the United States Government Accountability Office "found thousands of allegations of abuse, some of which involved death, at residential treatment programs across the country and in American-owned and American-operated facilities abroad… recorded by state agencies and the Department of Health and Human Services, allegations detailed in pending civil and criminal trials with hundreds of plaintiffs, and claims of abuse and death that were posted on the Internet. For example, during 2005 alone, 33 states reported 1,619 staff members involved in incidents of abuse in residential programs."[8] Chairman Miller's opening statement noted some particularly extreme details:

> " In far too many cases, however, the very people entrusted with the safety, the health and the welfare of these children are the ones who violate the trust in some of the more horrific ways imaginable. We are aware of stories where program staff members have forced children to remain in seclusion for days at a time, to remain in so-called stress positions for hours at a time, to undergo extreme physical exertion without sufficient
> food or water. And, today, we will hear evidence of even more horrifying stories of the children denied access to bathrooms, forced to defecate on themselves, or children forced to eat dirt or their own vomit, of children paired with older children, their so-called buddies, whose job it essentially was to abuse them. There is only one word for this behavior, and that is inhumane."

This report indicates that there is no specific federally regulated reporting requirement or definition for private programs. The main three causes of death were due to untrained staff, lack of adequate nourishment, and reckless or negligent operating practices

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[8] *RESIDENTIAL TREATMENT PROGRAMS Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth*, Committee on Education and Labor, House of Representatives Cong. (2007) (testimony of United States Government Accountability Office).

ASTART describes how "The treatment model provided in these centers involves a rigidly-controlled environment, strict discipline, confrontational therapy and a hierarchical level system of behavior change, in which upper level children take on staff roles and punish and control lower level patients. The level system is particularly problematic because when detainees are placed in positions of power, they continue the cycle of abuse. At Discovery Ranch, "snitching" and harsh punishments for peers are encouraged, to prevent any kind of solidarity from forming and potential rebellion from occurring. Feeling forced into abusing peers in the name of self-preservation can be an especially hard event from which patients must recover. These methods are used to address any and all problems a child might have, rather than case-by-case methods tailored to address specific needs. [9] In the face of this constructed incapacity and withholding of basic rights and autonomy, patients face a greater risk of abuse and neglect at the hands of their institutional caretakers, which is more likely to occur not only because of the physical isolation that is intrinsic to the very nature of these pastoral care-like institutions, but also because of the societal views often held by staff that dehumanize residents who exhibit behavioral problems, mental illness, or addiction. Rather than patients, these incarcerated teenagers are treated as inmates, punished on a daily basis as their "cure."

In 2013, the State Department compiled a fact sheet on "Behavior Modification Facilities," which they define by the following set of characteristics:

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[9] Alliance for the Safe, Therapeutic & Appropriate Use of Residential Treatment." *Stop Abuse in Residential Treatment for Troubled Teens*. Troubled Teen Industry: Help or Harm?, 16 Mar. 2015.

(1) The vast majority of students at these facilities are U.S. citizens or nationals;

(2) Students are often adolescents who have had serious behavior problems with their parents or guardians;

(3) In some instances, a U.S. state court has ordered students to attend the Behavior Modification Facility;

(4) U.S. citizen/national parents who place a child in these facilities typically sign a contract for their child's treatment that authorizes the facility's staff to act as agents for the parents;

(5) Contracts often give the staff blanket authorization to take all actions deemed necessary, in their judgment, for the health, welfare, and progress in the child's program;

(6) The facilities tend to isolate the children in relatively remote sites;

(7) Many employ a system of graduated levels of earned privileges and punishments to stimulate behavior change; and

(8) The Behavior Modification Facilities often restrict contact with the outside world, and the child's communication privileges may be limited.

The factsheet notes the difficulty officials have in intervening in potentially abuse treatment that occurs to children thus detained: "because these children are often kept in these facilities at their parents' wishes, but against their own desires, you may find them a difficult group to deal with and to monitor. It is the Department's policy not to interfere with the legitimate rights of parents to educate or raise their children as they see fit, so long as the living conditions and discipline meet generally acceptable norms." Despite this concession, the document urges officials to place a primacy on the wellbeing of U.S. citizens who are detained in facilities both domestic and abroad, and gives the following instructions:

"a. In some cases, abuse or mistreatment may be obvious, but often it is subtle. You should try to verify abuse, and to develop an informed opinion on the validity of any allegations. During your visits, always ask individual students if they are aware of any other students who might be having particular difficulties and then seek to interview anyone they might name. If you request Behavior Modification Facility management to make a specific student quickly available for an interview and they refuse, report this to the Department immediately. If a student alleges abuse or mistreatment, obtain as much independent verification as possible, by actions such as:

(1) Examining, and if possible photographing, any marks or bruises;

(2) Asking the student for the names of any witnesses, and interviewing them separately;

(3) Describing the abuse in general to other students, without identifying the alleged victim, to see if they verify the allegations;

(4) Get specifics. Having the victim describe in detail where, when and by whom the abuse occurred. This is important not only in verifying the abuse, but in taking appropriate follow-up actions; and

(5) If appropriate and possible, carefully examining the facility for any physical evidence that might support the allegations, such as a punishment box, whipping post, manacles or chains, etc."

Even state department officials have an uphill battle in legitimizing the cases of abuse they observe, and their findings and avenues of interference are at the whim of parental consent, which is usually uninformed and skewed by program officials' accounts of what is theoretically going on, even when observations include such horrifying evidence as "a punishment box, whipping post, manacles or chains, etc." State department officials who encounter such treatment programs are inherently objective observers, yet their accounts are at the mercy of subversion and discounting by people with a proven financial stake in the matter: parents, the consumers of these programs.

After over a decade of flying under the radar, Discovery Ranch made headlines in Phoenix, AZ on February 15th, 2015. The Courthouse Times reported that "[a] boy was sexually assaulted repeatedly at a residential treatment program for troubled teens, until his attacker was found committing bestiality with a horse… [even though] Discovery Ranch expressly promised to provide adequate supervision and care to ensure [his] safety." (Ross) The article documenting the family's ongoing lawsuit, staged on February 9th of this year, elucidates the conditions that allowed this atrocity to occur: "Discovery Ranch's merit system also prevented (him) from reporting the assaults because he believed that his inferior status and past interactions with Discovery Ranch staff and administrators would result in him being punished if he attempted to disclose the assaults," according to the complaint" (Ross). The merit system to which this is referring involves a hierarchical level system in which detainees are afforded more rights and

privileges, and detrimentally, more control over their peers, as they make their way up through the ranks. At levels four and five, detainees are essentially deemed "junior staff" and are allowed to police and punish their peers for infractions.

In contrast, this is how Discovery Ranch's new gender-specific boys' campus describes their mode of treatment:

> The Discovery Ranch treatment model is relationship based experiential therapy with a strength-based approach. Dialectical Behavior Therapy, or DBT, is a cornerstone of that foundation. We use a combination of traditional therapy methods with experiential therapeutic activities for real time, or in the moment, learning. The experiential approach is especially effective with treatment resistive students.
> Our strength-based approach helps students recognize the good in themselves as they work to overcome obstacles posed by various emotional and behavioral diagnoses. They develop self-confidence as they experience success in experiential assignments.
> Our working ranch campus provides the setting for those experiences. Each carefully structured activity gives students an opportunity to practice relationship skills in a variety of work and play settings.
> Through these therapeutic activities, we teach students life principles that are true for everyone, everywhere. We apply those principles to every situation our students may encounter during the course of their day. Therapists and mentors work with students until each principle is mastered. Those principles are:
> 3. Honesty
> 4. Respect
> 5. Responsibility
> 6. Hard Work
> 7. Service and Sacrifice
> 8. Accountability
> 9. Courage
> 10. Selflessness
> 11. Empathy
> Discovery Ranch students learn and practice these principles in an environment that replicates the responsibilities of adult living. During the process students, therapists, and mentors have a real timen opportunity to see the impact of behavior as it happens. They can address a student's behavior or concerns at the moment the student is most receptive to learning. Therapists and mentors will often stop an activity or conversation and ask a student, "What skills have you learned that you could use right now?"
> For Discovery students, motivation for therapeutic change comes from within the student, not from external pressures trying to exert internal change."

Systemic Abuse vs. "A Few Bad Apples"

Rather than these measures of abuse being isolated incidents that can be blamed on individual staff members, the proposed federal regulations, in conjunction with the large body of testimonies that are easily accessible yet often unread, indicate that this behavior manifests in response to the particular environment that is the basic premise of this brand of program.

"Behavior modification via "tough love" has no empirical, scientific evidence to support its efficacy; rather, it is promoted purely through anecdotal evidence, conveniently picking and choosing which feedback from parents and children who have experienced the programs to use" (Szalavitz, 378). Even if teenagers do not have diagnosable disorders or behavioral problems before they are enrolled in a "tough love" program, there is a far greater chance that they will develop such problems later down the road because of exposure to this type of environment. Thus emerges a catch 22: programs will happily take credit for a former client's success, yet are exonerated from culpability by labeling them inherently "troubled" or "difficult" teenagers from the start.

Wrongful incarceration is enabled and due process completely circumvented as minors have virtually no rights against their parents' decisions: "Under case law that allows parents near-absolute discretion over medical and educational decisions for their children, teens can be locked down without appeal until they reach age eighteen—and sometimes even longer" (Szalavitz, 118). This begs the question of how teenagers, who do not want to be incarcerated and have not been legally sentenced to prison time— nor medically evaluated and deemed a threat to themselves or others, thus necessitating psychiatric care— end up in these remote pastoral care centers to begin with? The answer is bizarre and shocking.

Institutions themselves often feature deplorable conditions and practices. One of the most traumatic components of incarceration in residential treatment is the use of escort services, namely burly individuals who parents hire to forcibly handcuff and drag their children out of bed in the middle of the night. “Pepper spray and mace are other tools often used to control and restrain detainees” (Teen Help, LLC). Many survivors who have been “escorted” to a residential program say they experience years of nightmares, flashbacks, emotional “numbing,” inability to concentrate, angry outbursts, difficulty sleeping or other symptoms” (ASTART). Flashbacks can be even worse than traumatic events themselves because unlike their cause, they lack a concrete beginning, middle, and end, and rather occur as an indefinite reliving, with no indication of when or where this will occur. Survivors often project their trauma onto all the unrelated stimuli they encounter, betraying a lack of “mental flexibility” in imagination. Rather than fantasizing about desirable and interesting things, imagination becomes limited to reliving and replaying versions of trauma, focusing on the past rather than the future, and invoking helplessness rather than hope.

Unfortunately, this singular traumatic event is compounded by months or years of further abuse.

Concrete evidence indicates that this behavior manifests in response to a stable environment. Phillip Zimbardo conducted a study of 24 college-aged males without any previous history of psychological problems, medical disabilities, crime, or drug abuse. Half of the volunteers were cast as guards and became extremely sadistic within days of the mock-prison scenario, while those in the inmate roles became powerless and obedient, enduring the torture and humiliation inflicted by the guards. They were

completely immersed in this simulated environment, despite all being volunteers, only being paid $15 a day, and being able to leave whenever they wanted.[10] This simulated environment shows how much more severe this power dynamic can become when prisoners or patients truly cannot leave, or are marked by a hierarchical difference.

What does this imply for children, there against their will, many of who do have psychological or medical disabilities? Children, especially those with significant difficulties, have much weaker defense mechanisms, and are far more likely to incur more extreme psychological distress and long-lasting impact. Zimbardo also conducted an adaptation of his original study at Elgin State Hospital, located in Illinois. In this case, rather than a complete role-playing scenario enacted by volunteers, the actual hospital staff were put in the shoes of those under their care. Zimbardo's study recounts that "[t]he vast majority of staff-patients (over 75 percent) reported feeling…"incarcerated," without an identity, as if [their] feelings were not important, nobody listening to [them], not treated as a person, nobody cared about [them]" (Zimbardo). This study successfully improved the staff-patient relations and quality of care. While the staff in this simulation merely felt this way, detainees in residential treatment centers are actively told things like that their feelings are not important, and that no one, especially their parents, cares about them. Due to this pejorative, condemning attitude, patients' complaints are consistently ignored, even in dire medical circumstances.

Regardless of the rationale behind a minor's incarceration, the label of "troublemaker" enables staff to disregard causal factors, and mete out abject punishment

[10] Zimbardo, Philip G. "The Mock Psychiatric Ward Experience." *The Lucifer Effect by Philip Zimbardo*. 2006.

to instill rule compliance with impunity. Furthermore, at the organizational level, such inevitable measures of abuse by staff are justified and explained away in terms of the supposed overriding benefits of turning a blind eye to such behavior. JTSP Volume 2 includes John Mercer of Mission Mountain School's "Integrated Risk Management Model for the Therapeutic Schools and Programs: Why the Risk is Worth Taking." This risk assessment posits the following oblique disregard and justification of the abuse it documents as regularly occurring:

> **Why Not Try to Eliminate All Risk?**
>
> "Risk is a fact of life and students need to learn how to manage and mitigate risk in order to have a full life. Adolescents naturally seek out risk as part of their learning experience. Learning how to successfully identify and manage risk is an important component in the process of adolescent development that helps facilitate self-esteem, concept, confidence, and competency (Dougherty, 2002)." (Mercer 74)

Despite terming certain risks "unacceptable" in the following sections, this sentiment is negated by this ambiguous and noncommittal caveat that precedes the more detailed incidents of abuse and neglect, thus implicitly condoning such behavior under the guise of the previous section's assertions about the supposed inevitability and even positive factors of "risk" in residential treatment centers:

> **What Risks Are Not Acceptable to the School Program?**
>
> Implementing risk in therapeutic school programming needs to be determined within the context of the mission, philosophy, goals, and policies of the program. This will vary from program to program. It is also constrained by law, regulation, and the concept of industry standard. […] Acceptable levels of risk occur when the likelihood of an adverse outcome is either so small that it is deemed to no longer be of concern or the mitigation of the risk is in place to offset adverse outcomes. Acceptable risk must be evaluated within the context of the school mission, philosophy, goals, and policies. What makes risk acceptable is strongly influenced by and may have to stand the legal test of the concept of a comparable current industry standard or principles of best practices" (Mercer 78)

This risk assessment plan's inclusion in NATSAP's literature indicates an endorsement of this abuse-apologist ideology across the board, despite the harrowing details that follow in the section entitled "Risks Associated with Staff Conduct":

> Most boarding schools invest a lot of energy into staff development and training to reduce the possibility of potential problems. However, prudence still requires schools examine and identify the potential risks that might arise through inappropriate staff conduct. The following is an inventory of potential risks associated with staff that might be found in a typical therapeutic boarding school. Each of these potential risks need a corresponding risk management plan to prevent their occurrence or reduce and mitigate the risk. Boundary issues. Assault/abuse/harassment – physical, sexual, or emotional. Inappropriate, exclusive, enmeshed, or enabling relationships. Substance abuse: - Under the influence at work. - Condoning substances. - Providing substances. Incompetence – below standard skills, capability, and or performance. Negligence – neglect: - Not following company policies. - Not fulfilling responsibilities.

This risk assessment posits no guidelines for reducing such behavior in program staff, nor does it suggest firing staff who behave this way or taking legal action against them. This attitude of leniency is echoed in the NATSAP public relations toolkit, which details how to publically manage incidents of abuse with the media. This toolkit includes a section on dealing with a crisis that makes no mention of repercussions for the abuser in question, nor does it suggest how to protect the wellbeing of the child who experiences abuse. Instead, the message to programs states that "on occasion, there is an incident that if handled incorrectly could reflect negatively on your facility and the therapeutic school and program community. Here are a few items to keep in mind to prepare you to manage a crisis effectively minimizing the damage to your brand and reputation. This media toolkit's attitude towards crises that impact students in programs' care reveals the underlying attitude that rather than addressing students' wellbeing, focus should be on "the most critical part of the crisis--reputation management. It also involves putting

together the lessons learned from dealing with the crisis and moving forward in a positive way with the least amount of damage done to your school or program." This attitude belies the entire premise that these programs intend to help the children in their care.

While NATSAP's literature scarcely discusses staff abuse outside the scope of reputation management, one article includes a model of therapy that is theoretically designed to monitor staff behavior called "Family Team Dynamics": "FTD is a weekly group process in which a therapeutic residential unit, comprised of direct care staff, the direct care supervisor and the therapist, engage in introspection and exploration, not about the children's lives, but about their own lives and their own relationships, with the children, the children's families, with one another. […]" In this article, a particularly disturbing case study outlines the primacy that is placed on staff's wellbeing at the expense of the children in their care, and uses charged language to frame the experience that indicates the skewed victim-blaming mentality about this resident's supposedly inherent culpability in her own past abuse, while exonerating inappropriate staff behavior:

> Case 1: In the FTD process, a male staff who was relatively new (about 1-year tenure) brought up that he had had troubling dreams about a young girl on the unit. He was mortified as he revealed the sexual overtone of the dream. As he talked, another male staff and a female staff revealed that they had also had sexualized dreams about this young girl, but had been too afraid to talk about it. None of these staff had experienced any sexual abuse as children and were in healthy age-appropriate relationships; this had been established in prior FTD sessions. All of the impacted staff, as well as other direct staff and the therapist in the group indicated that they had "felt sexual vibes" coming from the young girl, although they couldn't pinpoint the behaviors. At the next therapy with the child, the therapist noted that the girl talked about "tingly feelings" and asked her if she had those feelings about any staff. The little girl timidly acknowledged that she had and specifically mentioned each of the staff members who reported having the dreams. She then revealed for the first time the high sexual charge of her home environment and that one "uncle" had indeed had sex with her. The courageous revelation of the staff in FTD brought the team closer together and

> with a better understanding of the child. It ultimately helped the child access unacknowledged parts of herself and allowed the staff to intervene more directly with the girl to untangle specialness from sexuality. Because the staff no longer feared the feelings that this girl brought up in them, they no longer avoided her, and were able to sit with her as she experienced the guilt and shame over her traumatic past. (Kohlstaedt 21)

This case study details these staff's revelation that a female minor in their care was the victim of incestuous rape at the hands of her uncle. As if having sexually arousing dreams about this minor, who is completely subject to their control, is not bad enough, they go on to stage this abhorrent abuse as something warranting feelings of guilt and shame. Rather than encouraging staff to contact police about this incident of incestuous child sexual assault, the staff are encouraged to focus on the victim's negative feelings about herself in response to this act. Regardless of a child's "vibes" or sexual presence, it is completely unacceptable for adult staff to sexualize someone who is so dependent upon their authority. Rather than these adult staff members' responses being criticized by program officials, they are framed as somehow useful in a therapeutic process, theoretically because their sexual attraction to this child led to her disclosure of abuse. This supposed model of therapy, Family Team Dynamics, even explicitly involves a sort of amnesty for disturbing staff behavior and responses: "Information obtained in FTD cannot be used to terminate, although information which comprises a risk to self or others may be reported and dealt with through mandatory reporting laws deal with it within FTD or within their own therapy" (Kohlstaedt 21). Furthermore, this has not even been assessed in terms of proven efficacy: "The assumptions of correlations between FTD and increased tenure, team support and job satisfaction have yet to be demonstrated in a careful study" (ibid). Considering the primacy placed on the financial bottom line, the lack of regulation and accountability, and the paucity of funding that goes toward staff training and

development, it is no surprise that surveillance-based damage control is suggested in favor of proper vetting, training, or legal ramifications.

Commodifying Stigmatized Facets of Minority Identity

Theorizing Institutionalization

Institutionalization, at its core, is based on a hierarchical structure that defines a "patient" and a "doctor," as well as the "able" and the "disabled." This inherently translates to a binary of perceived badness and goodness, with the treatment providers or behavioral reformers cast in an altruistic light, and their practices given a wide ethical berth due to the supposedly beneficial result. This distinction creates both a desirable and undesirable set of characteristics into which every normative person is categorized. The similarities between the treatment involved in prisons, hospitals, and rehabilitative centers blurs the line between what constitutes a patient versus a culpable offender. French philosopher and theorist Michel Foucault proposes that institutions that claim to

cure, educate, and punish all use the same functional mechanism.[11] Many institutions that claim to treat, or even cure, their patients, yet respond to them in a way that is nearly indistinguishable from the legal treatment of criminals. Much of this conflation is enabled by the public perception of institutions, as staged by representative media.

Literary and Cultural Depictions of Institutionalization

The institution has long been made a caricature, a cultural trope seen everywhere from haunted houses to television and movies. The greatest detriment of this stigmatization is the public fear of the perceived danger associated with the institutionalized individual. Not only are institutionalized people staged as a threat to the general public, but the way institutions are depicted are also sensationalized to the point that they seem alien and distinct from everyday life. In terms of literature and memoir, very few accounts and depictions of for-profit behavior modification centers exist. Similar accounts mirror the experience of being isolated from society or contained based on mental illness, however.

Due to the obstacles institutionalized people face in telling their stories, many choose fiction to document their lived experiences. In her depiction of the effects of isolation on existing mental illness, The Yellow Wallpaper, Charlotte Perkins Gilman describes the “resting cure” treatment imposed on the semi-autobiographical female narrator, a treatment that Perkins herself was forcibly prescribed. This prescribed measure involved her total isolation and drove her mild depression up in scale to full-blown mania. While not a proper institution, her forcible treatment by a medical

[11] Foucault, Michel. Discipline & Punish: The Birth of the Prison (NY: Vintage Books 1995) pp. 195-228

authority, isolation in her room without human interaction, has a similar effect to the institutional use of solitary confinement. Sylvia Plath's pivotal work, The Bell Jar, similarly notes the use of isolation and societal exclusion to contain mentally ill figures. People literally did not want to see or acknowledge the existence of their neurodivergent peers, and justified this social exclusion by implementing a classification system related to intelligence and mental aptitude that totally devalued the intellectually disabled and mentally ill. Her semi-autobiographical character thinks "finally, when the money was used up, they would move me to a big state hospital with hundreds of people like me in a big cage in the basement. The more hopeless you were, the further away they hid you" (Plath 160). Those in power desire not only to isolate and deny the humanity of their supposedly "lesser" fellow humans, but they also refuse to acknowledge the cruelty of this ostracizing expulsion from society. The fundamental idea that institutionalization and abusive measures are justified by the stigma and fear with which mentally ill people are condemned is elucidated when Plath's Esther "wonders what terrible thing it was [she] had done" to deserve the horrific pain and subjugation of electroshock therapy, and later her incarceration in an institution. Ultimately, her treatment was predicated on her failure to adhere to the role she was ascribed by her family and society as a whole, and her incarceration was based on her mother's decision. Despite this internal query, she does not express this confusion to her doctors who have thus treated her, even though she theoretically has the linguistic and communicative ability to do so. She knows that the position into which she has been put in her contemporary society has muted her voice, and that neither reason nor emotional appeal will save her from her medicalized prison.

A current example of the mockery that is made of psychiatric treatment is evident

in the popular TV show, American Horror Story: Asylum. The second season of this show takes place "in the unrelentingly bleak Briarcliff Manor, a Massachusetts mental hospital that's run by the vicious sister Jude… and, of course, filled with secrets" (Chancey). The nun who oversees the asylum, Sister Jude, believes that "mental illness is the fashionable explanation for sin" (FX, 2012). This line is particularly compelling in light of the frequent, yet often unacknowledged, religious affiliations that exist in troubled teen treatment centers. The underlying attitude held by those in charge of these institutions, in regards to the treatment of mentally ill "patients" in their care, largely stems from religious beliefs about sexual purity and strict abstinence from substance use of any kind. AHS: Asylum features a "nymphomaniac" female character, which is representative of the societally normative pathologization of females as overly sexual. This commercially successful TV show stages institutionalization in an asylum as something so far-fetched and sensationalized that it is divorced from reality completely, which derails critical discourse about the reality of institutionalization.

Susan Nussbaum's Good Kings, Bad Kings exemplifies the notion that institutions that position themselves as the antidote to violence, illness, homelessness and death within the disabled community actually ensure that these outcomes befall its supposed "patients," rather than prevent them. ILLC, an institution for the physically and cognitively disabled, is an excellent model for problematizing the modern institution. Patients are subjected to constant surveillance, a hierarchy of needs, abusive staff members, and other mechanisms of control that not only insure the functionality of the institution as a company and biosphere, but which also instate learned helplessness in its patients. As is typical of all institutions, it shadows domestic life outside of the

institution, while still propagating familial abandonment. The mechanisms of control that the institution uses include the punishment room— where kids are held alone for misbehavior— as well as taking away freedom and mobility— such as limiting who can use an electrical chair, use the elevator, go on the grass, or take the bus alone. Through these methods, child patients are trained to stay helpless so that they never leave institutions, and Nussbaum reveals the financial motive for shaping them to be this way. For example, Whitney Palms, who functions as a sort of educational consultant, receives $300 for every bed she fills, regardless of whether or not they would benefit from being there. Real-life educational consultants are unlicensed, rarely meeting or talking to the children for whom they assign placement at facilities, and such consultants receive financial kickbacks from the programs they help fill.

The Origins of American Institutions

Disability rights activists have made comparisons between institutions founded on the premise of eugenics and ones that claim to treat mentally disabled or ill Americans: "Pointing to the origins of institutionalization in the United States in the eugenics period of the early twentieth century—and to similar treatment of individuals with disabilities in Nazi Germany—they also argued that institutionalization rested on and instantiated prejudices against people with disabilities. Some went so far as to adopt Thomas Szasz's view that mental disability is a "myth" or a label attached to certain societally deviant people" (Bagenstos 20). This conflation of madness with personal deviance or social ill is historically preceded by one of the most contentious movements in modern medicine.

Foucault's Language, Madness and Desire contains an interview with Jean Doat, entitled The Silence of the Mad, in which Foucalt discusses how mentally ill people were

deprived of a voice and of autonomy by both the public at large and by the government. Not only were the voices of the "mad" discredited and made into a mockery of logic and reason, but these people themselves were also cordoned off from society, and indiscriminantly institutionalized along with criminals:

> One day in April 1657, nearly six thousand people were arrested in Paris. Six thousand in seventeenth-century Paris, that's nearly a hundredth of the population. It's as if, for example, we were to arrest, in today's Paris, something like forty thousand people. That's a large number and we would hear about it. They took those people to the Hôpital Général de Paris.[4] Why? Oh, because they were unemployed, they were beggars, they were useless, they were libertines, eccentrics, and they were also homosexuals, madmen, the insane. They were sent to the Hôpital Général although no one, at any time, had taken any speci c legal steps against them. A precautionary measure by the police, an order from the king, or even—something more serious from my point of view—a simple request by the family, was sufficient to send all of those good people to the hospital, and for life. Obviously, there was nothing hospital-like about this hospital; it was more like a large prison, where people were held in custody, often for life.
>
> This practice lasted for nearly a century and a half and, from this enormous ritual of exclusion, which was, by the way, rarely questioned, we retain no more than a few dusty record books, currently stored in the Bibliothèque de l'Arsenal. And in those records, what do we see? Well, we find the lengthy rhapsody of the reasons for internment.
>
> I feel they're worth listening to, those decrees that logic, the logic of the state, which is to say, ultimately, the logic of the police, and the logic of everyday people, directed at the madness of others. 14

The institution, whether it be prison, rehabilitation center, or psychiatric ward, seeks to cure, educate, and punish all at once. These three components of behavior modification are all designed to maintain "normalcy" and return the "disturbed" back to a normative state through whatever means necessary. This indiscriminate mistreatment is enabled because "our cultural ambivalence about the status of disabled people bolsters a desire to ignore the disastrous legacies evident in a history of collecting, defining, naming, measuring, and managing them as "feebleminded", "subnormal", or simply

"defective" humanity. (Snyder and Mitchell 102). While students are constantly assessed in terms of how they are, to use these institutions' jargon, "working the program," and surveilled 24 hours a day to measure their arbitrarily defined progress, this approach does not account for the fallibility of this type of "training." Rather than positing a flawed subject, the real problem is the technique that authorities employ. This mindset is reinforced when program administrators label complainants "losers" or "failures" to compensate for the failure of the institution's ability to make patients conform.

The figure of the institution is nearly inseparable from the field of Eugenics, which heavily relied on "pastoral care" as a mode of segregation to remove disabled bodies from the general popular and control their interactions with "healthy" members of the gene pool. These institutions sought not only to segregate disabled people, but also to return them to a state of normalcy via behavior modification. Eugenics "invented the category of disability that grouped people with widely divergent physical and cognitive characteristics under a single heading of 'defect'" by restricting their rights and social liberties (Synder and Mitchell, 113). The idea of a binary is created between normal and feebleminded persons, a distinction that creates a desirable and undesirable set of characteristics, into which every person is categorized, using a "[c]atalogue of defective conditions- epilepsy, feeblemindedness, deafness, blindness, congenital impairment, chronic depression, schizophrenia, alcoholism- adopted by European and North American eugenics engaged in a shared campaign of biological targeting that addressed deviance as a scourge to be banished from the transatlantic hereditary pool " (Mitchell and Snyder 103). Many of the mechanisms of control that Mitchell and Snyder note are seen in the behavioral modification methods of troubled teen programs. Seguin's

approach stressed rote repetition (as the program has a fixed schedule and is completely inflexible), incremental discipline involved in gymnastics training (forced physical labor), and stages that “insufficient mastery of will, defect of self control… could not be remedied without continuous surveillance and the oversight of institutions that would fill one’s days." Institutional training sought a way to rescue those classified as “idiots” from “mental darkness.” Samuel Howe notes that these training institutions would “not only salvage degraded lives but also relieve families of rearing defectives in the community.” Michael Newton notes the contemporary derivations of these centers: “more strangely, these same phrases are used for those few children [today] who have lived through another perhaps crueler kind of loneliness, locked for years in solitary confinement in single rooms… what contemporary scientists today would classify as those with “severe behavioral disorders.” This description seems to match the exact designations of programs within the troubled teen industry.

Examining Troubled Teen Programs Through the Lens of Disability Theory

The American Disability Rights Movement has achieved critical achievements in its fight for civil rights of disabled American citizens. Much of the success this movement has seen is the direct result of altering the public conception of what disability actually is, which is encapsulated by the cripistemological mode of thought that includes disabled bodies in rationalizing and justifying social structures. Disability advocacy is preceded by a long history of discrimination. Disabled people were banned from employment in original 13 colonies, and the “Ugly laws” in several American cities from the 1860’s until up to 1970s banned people of unsightly appearance from public ways, and decreed that no person who is diseased, maimed, mutilated, disgusting object should

be allowed in public view. This exclusion prohibited the disabled from working and living within their community, and such ostracizing took firm shape in the confinement of disabled people within institutions.

So much of the plight of youth who are confined within these residential treatment centers hinges on the public conception of who they are, what value judgments are ascribed to their facets of self, and the acceptable way to treat them that is proposed and endorsed based on these characteristics. Epistemology considers the nature of knowledge, justification, and the rationalization of belief. Knowledge is ultimately shaped by public norms and discourse, and therefore how behavior is justified hinges on the way we come to believe things are true. Belief systems, however, are based on normative ideologies that cater to the hegemony, often at the exclusion of non-normative people. Merri Lisa Johnson and Robert McRuer propose that disability studies must take on a new method of knowing that includes disabled bodies, which they term "cripistemologies." This proposed theory challenges the current crisis of exclusion: "thought and knowledge in twenty first-century Western culture as a whole is structured—indeed, fractured—by an endemic crisis of ability and disability. […] an understanding of virtually any aspect of contemporary Western culture must be not merely incomplete, but damaged in its central substance to the degree that it does not incorporate a critical analysis of able-bodied/disabled definition and the appropriate place to begin is the relatively decentered position of crip, anti-ableist theory" (Johnson and McRuer 131). Cultural modes of epistemology shape not only public policy, but also the fundamental social dynamics that inform the quality of life for each individual subject to this framework. For significant progress to be made that will protect the rights and

wellbeing of the unprivileged, those who do not have power and autonomy, necessitates a shift in discourse that affirms the humanity and worth of those who are subject to the power of others.

The shift from the medical model to the social model of disability, as well as the movements for independent living and deinstitutionalization, all directly apply to the problem of incarceration within the troubled teen industry: “To most disability rights advocates, “disability” is not an inherent trait of the “disabled” person. Rather, it is a condition that results from the interaction between some physical or mental characteristic labeled an “impairment” and the contingent decisions that have made physical and social structures inaccessible to people with that condition. The proper remedy for disability-based disadvantage, in this view, is civil rights legislation to eliminate the attitudes and practices that exclude people with actual, past, or perceived impairments from opportunities to participate in public and private life.” (Bagenstos 15). The medical model, which “focused on medical treatment, physical rehabilitation, charity, and public assistance […] treated disability as an inherent personal characteristic that should ideally be fixed, rather than as a characteristic that draws its meaning from social context. […it] encourages dependence on doctors, rehabilitation professionals, and charity. […] Martha Minow’s “social-relations approach” to difference “treats human differences as constructed by, and residing in, social relationships. […] disability should not be considered to be the unmediated product of limitations imposed by a physical or mental impairment. […] The social model instead treats disability as the interaction between societal barriers (both physical and otherwise) and the impairment.” (Bagenstos 19) Disability has continuously been used as a marker of hierarchical relations. When it is

construed as a sign of inferiority, it is a signifier for things we want to disavow or devalue. Abnormality is used to justify hierarchy by isolating specifically those who are deemed "less than" normal. Reducing disability to a personal tragedy or individual plight put the rights of disabled individuals at the whim of privileged peoples' charity and altruism, rather than recognizing the fundamental need to systemically overhaul barriers to access and inclusion at the social level.

One of the primary successes of the disability rights movement has been deinstitutionalization for adults confined to psychiatric hospitals and institutions on the basis of their impairments: "At the beginning, the deinstitutionalization movement was largely led by nondisabled lawyers, journalists, and psychologists with a civil libertarian or civil rights bent. But as it moved forward, and more and more people were deinstitutionalized, individuals with mental retardation and mental illness began to organize their own advocacy groups.[..] People with mental illness formed a "psychiatric survivors" movement that similarly sought community treatment, as well as freedom from involuntary medication" (Bagenstos 21). Minors, however, have less access to legal retribution for their incarceration and forced medication, the latter of which is often used as a mechanism of control. Their path to freedom is blocked, in turn, by the parental authority that supersedes their rights as private citizens, and the staging of their disabilities as morally charged conditions of being bad or troubled precludes them from this advocacy. Disposable Youth reveals the current cultural modes of thought that devalue teenagers who are marked by difference, and how these differences are used to demean their worth and exclude them from the social narrative: "More and more young people are caught in the punishing circuits of surveillance, containment, repression, and

disposability […] In the current historical moment, young people are increasingly defined through a youth crime-control complex that is predatory in nature and punishing in its consequences, leaving a generation of young people with damaged lives, impoverished spirits, and bankrupted hopes" (Giroux 4). This phenomenon of exclusion and torment is not simply confined to juvenile detention centers. Rather, such an attitude is evident in all institutions that claim to practice behavior modification through punishment.

The greater the impairments that adolescents face, the more vulnerable they are to abuse and neglect. Inherent lack of power within these individuals enables the totalitarian power structures within residential treatment centers to fully incapacitate them. One of the most physically dangerous practices used by staff, often on children who are considered a runaway risk, is the use of isolation (solitary confinement) and stress positions. The GAO report on Seclusion and Restraints notes that staff often inflict these measures on the most vulnerable of residents:

> **Children with Disabilities:** Although we did not specifically limit the scope of our investigation to incidents involving disabled children, most of the hundreds of allegations we identified related to children with disabilities. In addition, 9 of our 10 closed cases involve children with disabilities or a history of troubled behavior. The children in these cases were diagnosed with autism or other conditions, including post-traumatic stress disorder and attention deficit hyperactivity disorder. Although we did not evaluate whether the seclusion and restraint used by the staff in our cases was proper under applicable state laws, we did observe that the children in the cases were restrained or secluded as disciplinary measures, even when their behavior did not appear to be physically aggressive. Children, especially those with disabilities, are reportedly being restrained and secluded in public and private schools and other facilities, sometimes resulting in injury and death. The 10 closed cases we examined illustrate the following themes: (1) children with disabilities were sometimes restrained and secluded even when they did not appear to be physically aggressive

> and their parents did not give consent; (2) facedown or other restraints that block air to the lungs can be deadly; (3) teachers and staff in these cases were often not trained in the use of restraints and techniques; and (4) teachers and staff from these cases continue to be employed as educators. In addition to the 10 cases we identified for this testimony, 3 cases from our previous testimonies on residential treatment programs for troubled youth also show that face down restraints, or those that impede respiration, can be deadly. (**7, GAO-09-719T)**

Appropriating Educational Accommodations

Not only do these programs fail to provide a legitimate high school education to students, but they also take advantage of state measures used to support children with learning disabilities by appropriating Individual Education Plans. Branding themselves as academic institutions that facilitate IEPs not only deprives students of the specialized education they need, but it also allows them to solicit reimbursement funding from states on this basis. This goes against the progress that disability rights activists have achieved: "Another strand of the movement that developed in the early 1970s sought access to elementary and secondary education. At the time, public schools were free to deem individual children with disabilities "uneducable" and refuse to provide them any education. In 1975, Congress found that more than a million children with disabilities nationwide were entirely excluded from public education, and millions of others were excluded in significant respects. Civil rights attorneys like Marian Wright Edelman joined with parents and special-education teachers to challenge that massive exclusion. A series of largely successful law- suits throughout the country was followed by Congress's enactment in 1975 of the Education for All Handicapped Children Act (later renamed the Individuals with Disabilities Education Act), which guaranteed all children with disabilities a "free appropriate public education" in the "least restrictive environment." (Bagenstos 16-17). One website that advertises troubled teen programs, All Kinds of

Therapy, provides guidelines for parents to use state educational resources to pay for their child's incarceration in a program by hiring educational consultants to frame such out-of-state placement as pursuant to the Individuals with Disabilities Education Act[12]. In OAH Case No. 2014120525, parents of a student they placed at Discovery Ranch successfully petitioned the San Diego Unified School District for "compensatory remedies in the form of reimbursement of monies paid to Discovery Ranch […] Parents were able to obtain a $900 per month discount." These parents were able to bring this case under "the Individuals with Disabilities Education Act, its regulations, and California statutes and regulations intended to implement it. (20 U.S.C. § 1400 et. seq.; 34 C.F.R. § 300.1 (2006) et seq.; Ed. Code, § 56000, et seq.; Cal. Code. Regs., tit. 5, § 3000 et seq.) The main purposes of the IDEA are: (1) to ensure that all children with disabilities have available to them a FAPE that emphasizes special education and related services designed to meet their unique needs and prepare them for employment and independent living, and (2) to ensure that the rights of children with disabilities and their parents are protected. (20 U.S.C. § 1400(d)(1); See Ed. Code, § 56000, subd. (a).) FAPE means special education and related services that are available to an eligible child at no charge to the parent or guardian, meet state educational standards, and conform to the child's IEP. (20 U.S.C. § 1401(9); 34 C.F.R. § 300.17; Cal. Code Regs., tit. 5, § 3001, subd. (p).) "Special education" is instruction specially designed to meet the unique needs of a child with a disability. (20 U.S.C. § 1401(29); 34 C.F.R. § 300.39; Ed. Code, § 56031.)" The results of this case indicate that "Parents were entitled to unilaterally place Student because

[12] https://www.allkindsoftherapy.com/blog/can-your-school-system-help-with-treatment-options--8-questions-to-ask-

District denied him a FAPE after the April 2014 IEP. Student is entitled to reimbursement for appropriate costs associated with the placement. However, several factors warrant a reduction of full reimbursement, including Parents' failure to timely notify District of the unilateral placement, as well as choosing a private, residential placement in Utah without demonstrating consideration of a private, day treatment placement closer to home." While the findings of this case clearly indicate that the student did not want to be there and did not find the placement suitable, even going so far as to cite his suicidal ideation based on the treatment he received, his own opinion was superseded by that of his parents based on seemingly arbitrary markers of his progress. Soliciting teenagers for placement by posing as specially accommodating academic institutions, and encouraging parents to seek state IEP funding for this placement, is diametrically opposed to the intent of these measures, namely, to support, accommodate, and include children with learning differences.

Psychological Ramifications of Prolonged Institutionalization

Within troubled teen programs, students' impairments are used as a basis for their restriction from both society as a whole, and the environments they create also limit their ability to function both independently and interpersonally. In response to the trauma they endure, it is extremely likely that even neurotypical and mentally healthy youth will develop debilitating levels of PTSD that render them disabled for life once they leave. Not only do most youth in these programs have conditions that involve a level of disability to begin with, like mental illness and cognitive difference, but these programs also create disabled bodies via their extreme mechanisms of control. For example, in the case of the death of Aaron Bacon in the North Star wilderness program, "Bacon became a

‘disabled child’ the moment he came under North Star’s control. His disability was caused by the conditions in the program, which made him unable to provide his own food, clothing, and shelter and prevented him from seeking medical attention” (Szalavitz, 189). Despite the array of deciding factors for placement, the treatment students experience is formulaic, rather than specified, which not only exacerbates existing problems, but also creates a high risk for causing new mental health problems.

The restriction of basic rights and autonomy makes students unable to function as able-bodied individuals, and are thus completely dependent upon the staff who control their lives. Not only is the experience of physically residing in these institutions intolerable, the repercussions of being subjected to such treatment extend for years after incarceration. Post- Incarceration Syndrome (PICS) results from an extended length of institutionalization and includes four main symptoms:

Institutionalized personality traits: learned helplessness, antisocial defenses

PTSD, antisocial personality traits: developed as a coping response to institutional abuse

Social- sensory deprivation syndrome: caused by prolonged solitary confinement

and substance abuse disorders to manage or escape PICS symptoms. (Gorski).

Emotional numbness or distance is a terrible plight for survivors of trauma, often experienced as an ability to feel aside from moments of extreme rage or shame or pain. In addition to inherent feelings of numbness, trauma survivors also seek out behaviors, substances, and distractions to externally numb the pain they want to escape. The primary effect of prolonged institutionalization due to criminal or mental health concerns is a high rate of relapse and recidivism due to the climate of the institution itself.

Furthermore, “being put in any kind of situation of total powerlessness for a significant length of time has the capacity to produce lasting damage to the brain’s stress system, especially when it happens to a young person.

PTSD does not lurk solely in the realm of the mind: “This damage has been linked not only to PTSD, but to increased risk for depression, addiction, other mental illnesses, and even immune-system disorders and cancer” (Szalavitz, 405). Van der Kolk’s prologue to The Body Keeps the Score notes the incredible resilience of human beings when it comes to coping with disastrous experiences, a resilience that is contextualized by the immense difficulty of countering and living with the traces that impact our “minds and emotions […] biology and immune systems,” and the “tremendous energy” it takes to continually push away the painful memories and thoughts. While he terms trauma inherently “unbearable and intolerable,” the brain’s neuroplasticity can be used to help survivors mitigate or even reverse the damage, and feel fully alive and capable. Traumatic response is continuously and easily physiologically reactivated in response to the threat of danger, which “mobilizes disturbed brain circuits and secretes massive amounts of stress hormones,” termed “hypervigilance,” and often leads to impulsive and aggressive actions, often repeating the same problems and having trouble learning from experience. This is not a moral failing or weakness of will, but rather the result of changes in the brain. Trauma recalibrates the brain’s alarm system, altering how relevant information is sorted from irrelevant material, and ultimately the “physical, embodied feeling of being alive.” The somatic impact of trauma is crucial in revealing that PTSD is not “all in one’s head,” but is rather a somatic response to lived events. Brain imaging has proved a useful tool for evidencing the

results of trauma in a particular and somatic manifestation, and thus “entirely new avenues of repair” of the imprints left on the brain, mind, and body, which impact how the organism survives in the present. Trauma alters not only how we think and what we think about, but also our very ability to think. Treatment requires not only the ability and opportunity to talk about what happened, but also for the body itself to learn that the trauma has ended and recognize the distinctness and safety of the present.

In his study on violence in the institution, H. J. Schneider reveals that “learned helplessness in institutions provides a victim-oriented explanation of violent behavior and abuse: the hostile environment cannot be changed by the incarcerated person’s actions”. The factors that most powerfully pave the way for institutionalized abuse of the incarcerated include unequal distribution of power and a high visibility of power structures, as well as the environment of the institution itself, rather than those who reside within it. Learned helplessness as a result of institutionalization, whether in a formal, brick-and- mortar institution or a more cognitively constructed mechanism of isolation for the “non-normative” person, not only exacerbates existing impairments, but also cultivates a potentially deadly inability to function in the outside world. Behavior modification via “tough love” has no empirical, scientific evidence to support its efficacy; rather, it is promoted purely through anecdotal evidence, conveniently picking and choosing which feedback from parents and children who have experienced the programs to use (Szalavitz, 378). By depriving individuals of basic autonomy as an answer to their deviation from a normative image of the able-bodied individual, the institution often exacerbates, or even creates, the problem of impaired functionality that it claims to “cure”. Based on the psychological impact on both the doctor, guard or teacher,

and the patient, prisoner, student, consumer, or survivor, the end result is the same: authoritarian control inevitably creates the risk of an abuse of power, while captivity inherently negatively impacts the very people it claims to help, on an acute and long-term basis.

The findings of Jonas' study on patient behavior in hospitals indicate that poor performance in cognitive tasks increased in correlation with length of hospitalization, which also made patients more susceptible to the debilitating effect of uncontrollable events. [13] "Bad patients" exhibited antisocial behaviors and excessive opposition, while many of them gradually shifted to become "good patients." In becoming a "good patient"— namely passive, compliant, and inanimate— hospitalized persons lose their ability to navigate daily life outside the institution, becoming unable to adapt to change or to self-advocate. In behavior modification programs, these three characteristics are desirable in order to keep kids under control and minimize rebellion. These quasi-results are also exactly what parents want from their "troubled," rebellious teenagers— a dramatic switch to docile and meek is, in their eyes, precisely what they are paying for. This ultimately fails to account for the long-term recidivism towards "bad patient" antisocial behavior, and the detrimental effect of long-term lack of individualism.

The traumatic symptoms of incarceration and abuse, in turn, blocks them from access and inclusion even when they are reintegrated into society. How society understands disability defines how it includes or excludes the individual. Rather than isolated cases of impairment, disability advocacy creates a group bound by common

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[13] Jonas, M (06/01/1982). Patient Behavior in Hospitals: Helplessness, Reactance, or both? Journal of personality and social psychology. 42 (6), p. 1036. (ISSN: 0022-3514)

social and political experience, and who endure a common marginalization. Thus, a community of disabled people who share a common experience of oppression can function more cohesively to advocate change than an individual can remedy their personal oppression. While disability comprises a wide spectrum, the idea that "we're all disabled in some way" should not erase this line as long as disabled people are discriminated against.

Ethics of Dependency in an Institutional Setting: Staff and Student Relations

Until a system of oversight and regulation is implemented, these institutions and programs will continue to exist, incarcerating thousands of "problem children" each year who experience mental illness, substance abuse and dependence, eating disorders, neurodivergence, cognitive difference, or who simply exhibit subjectively "negative"- in the parents' eyes- traits or habits, such as LGBT status, or genuinely problematic behaviors that make them difficult to parent. In the meantime, it is crucial to define a system of ethics for staff that work within any institution for legal minors, legitimate or not, that is predicated on cultivating dependency and removing basic autonomy as part of their program or treatment, whether or not the child's "condition" is one that involves inherent dependency. Equally important, the fact remains that many reasons that prompt parents to send their teenagers to such institutions are, indeed, problems that necessitate specific types of care. The behavioral problems that stem from mental illness and cognitive disability are an inherently difficult condition to treat, all the more so in the case of minors who have few individual rights under the law, and whose treatment plans are dictated by the adults in charge of them.

Eva Kittay and Stacy Simplican explicate, respectively, relationships of such

dependency, and affirm the needs not only of the person with less power, but also those of the dependency worker entrusted with their care. While a markedly different dynamic, institutional dependency, especially in the case of minors, is applicable to both sets of theory. People who work in Troubled Teen residential treatment centers meet the definition of dependency workers, namely attending to the well-being of and thriving of dependents, whether in the home, nursery, or hospital. It is labor that enhances the power and activity of another- when they cannot do so themselves. This dynamic within such institutions is unique because the reason charges "cannot do things themselves" is due inherently to the rules and control implemented by the institution itself, and thus Kittay's "Three C's" apply: these workers tend to others in a state of vulnerability (care), and certainly have a connection via economic exchange, yet the "concern" (affectional ties) component is actively discouraged in the "tough love" treatment model. (Kittay 31) These workers are often paid minimum wage and receive little training, which raises the need for connection based equality- they are tasked with a custodial and surveillance based role to maintain power dynamics, in a model that neglects both their needs and those of the teenagers in their care.

These institutions actively stage dependency by stripping teen residents of their power and autonomy, often when they are not what would be defined by socials norms as inherently "dependent" people. Thus, the relationship between staff and students is more like Kittay's concept of "extended dependency work," yet notably functionally diffusive and sustaining- to lengthen lucrative stays- rather than being functionally specific and interventionist, which is often what "troubled teens" truly need, in all the connoted conditions that label entails. (Kittay 38) Thus, the inequality of power is not inherent to

these teenagers' conditions, but rather due to the "exertion of domination in a relation of inequality wherein the dependency worker uses power against the charge's will, as if they were property," which in effect, they are, because the longer they "need to be there" the more money the institution makes, month by month. (ibid)

An important component that distinguishes relationships of dependency from organic relationships is the inclusion of payment and wages. The financial devaluation of the dependency work residential staff must perform exemplifies Kittay's stance that such work is underpaid and underappreciated. Despite the exorbitant fees, usually topping $10,000 per month per student, the actual dependency workers, namely the staff who interact with teenagers on a daily basis, are paid negligibly. Whereas education consultants have an estimated median salary of $62,000 which does not even account for the undisclosed referral fees, most their income, staff like those who work at places like Discovery Ranch are paid an $8 minimum wage, according to Glassdoor[14], which is Utah's minimum wage. Furthermore, Brigham Young University even advertises positions as "mentors" as unpaid internships in which undergraduate students can participate. In my experience, and in that of others I've spoken with, staff turnover is incredibly high due not only to the meager pay, but also the lack of training and generally negative and disturbing nature of the work they are expected to do. The qualifications of staff are entirely ambiguous and ideological rather than concrete. A recent Indeed job posting lists the following solely subjective qualifications: "Exceptional relationship skills, Dependable, Demonstrate the ability to hold appropriate boundaries and distributing consequences as appropriate, previous work with mentoring or youth

[14] https://www.glassdoor.com/Salary/Discovery-Ranch-Salaries-E993382.htm

preferred, and must be 21 years or older to apply.[15]" Not only does this job description lack legitimate credentials, but it also glosses over the harrowing nature of the work that it solicits.

Despite being marketed as clinically sophisticated centers full of well-trained staff, yet another study from NATSAP's JTSP reveals the truth about who students interact with for the majority of their stay, and thus the actual level of care they receive:

> [Direct Care Staff] who work in RTCs are paraprofessionals in the human service and mental health field (Leon, Visscher, Sugimura, & Lakin, 2008). DCS work directly with clients for periods of eight to ten hours per day, four to five days per week. According to Pazaratz (2000), DCS have among the most critical and difficult positions in treatment centers because of their job duties (i.e., nurturing, disciplining, helping with homework, providing meals, managing crises, helping set goals, facilitating psycho-educational groups, supervising recreational activities, and charting). Other duties include ensuring clients safety; transporting clients to appointments; and in some cases when a client becomes a danger to self or others, physically managing the client. DCS may be exposed to behaviors such as spitting, hitting, biting, hair pulling, self-injurious behaviors, and verbal abuse. DCS have the second highest turnover rate in public RTCs - the first-highest turnover rate is the housekeeping staff (Connor et al., 2003)" (Stapleton, Young and Senstock 77-78).

Despite constituting most staff members in number, and essentially having the most work to do and the majority of contact with students, these "para-professional" Direct Care Staff, usually termed "mentors" on official program documents while being termed "night shift workers," "supervisors," or "child care workers" in official studies like the ones below indicate that they receive the smallest portion of compensation:

[15] https://www.indeed.com/cmp/Discovery-Ranch/jobs/Part-Time-Mentor-Residential-Treatment-Facility-f722dc93f1e9cbb2?q=Discovery+Ranch

Position	Number of programs reporting an average salary	Minimum average salary reported	Maximum average salary reported	Mean average salary reported
Admissions	55	$25,200	$90,000	$45,044
Ph.D. Level Teacher	6	$40,000	$55,000	$48,000
Masters Level Teacher	42	$25,000	$55,000	$39,482
Bachelors Level Teacher	40	$18,850	$54,000	$33,728
Ph.D. Level Therapist	26	$45,000	$100,000	$65,881
Masters Level Therapist	58	$30,000	$80,000	$48,062
Child Care Worker	61	$14,000	$37,000	$25,961
Night Shift Staff	47	$12,800	$35,000	$22,643

Having autism, mental disability, or a mental illness is not illegal or unethical, and few people would openly endorse punitive treatment in these cases. In the alternative mode of the institution, however, such conflation is the norm.Behavioral problems related to mental disability, when left untreated, can have dire consequences. When an institution claims to treat not only these conditions, but also to function as a reform school for bad behavior, disability and illegal behavior become indistinguishable. In this environment, staff who function as dependency workers are far more likely to exhibit abusive and punitive measures towards their charges, as well as incurring more violence and resentment from those in their care. This purposeful equivocation hurts not only institutionalized teenagers, but also staff who might have been hired under false pretenses, and who most certainly are not properly trained or equipped to handle each

type of “troubled teen” in their care.

Dependency is cultivated in residents not only in relation to staff, but also to each other via a stratified system of rights and privileges, and autonomy. The level system, in particular, is problematic because detainees tend to continue the cycle of abuse when they are placed in positions of power. In fact, “snitching” and harsh punishments for peers were encouraged, to prevent any kind of solidarity and potential rebellion from occurring. Mercer’s same “risk management” includes a section on risks associated with student behaviors, and the editorialization and tone reveal the pejorative attitude widely held among these communities:

> **Risks Related to Student Behavior** Student behavior is an area where there can be significant potential risks. Most therapeutic boarding schools invest a lot of time and energy in developing and implementing behavior management strategies to both engender positive pro-social change in behavior as well as to minimize and manage “risky” student behaviors. These potential risks may occur in any therapeutic school. […] The following is an example of unacceptable “risky” student behaviors: Harm to others: • Homicide. • Physical or sexual abuse or assault. • Hazing/teasing/abuse. • Theft. • Destruction of property. Harm to self: • Suicide. • Self-mutilation. • Risk taking or thrill seeking. Other problem issues or student behaviors that may cause harm: • Runaway. • Impulsiveness. • Preoccupation/stress. • Clumsy/accident prone. • Inattentive. • Inflated sense of abilities or accomplishments. Addictive Illness: • Substances. • Food/eating disorders.

The stratified power distributed by the level system ensures that not only are adolescents who are predisposed to, or have had a track record of, violent or aggressive behavioral problems given free range to abuse their peers who might not have such predispositions, but they also are continuously baited into exhibiting the problem behavior that supposedly necessitates their incarceration. Rather than de-escalation and socialization being goals, teenagers are constantly forced to recognize the worst parts of themselves, which perpetuates anger and violence, and then resulting punishment, enabling a

perpetual cycle that indicates month after month that the minor is “not ready to go home” and “needs more treatment.”

These student behavioral risks not only occur interpersonally among residents, but also pose a threat to the underpaid and underqualified staff who supervise them. Being exposed to abusive behaviors by students leads directly to not only retaliation or escalation of mistreatment or neglect, but also staff turnover, burnout, and “compassion fatigue,” which is a result of Secondary Traumatic Stress from working around the clock with youth who show signs and symptoms of PTSD. Simplican’s analysis of Trudy Steurnagel’s death at the hands of her autistic son, Sky, shows the gravity of such a situation in which the resources are not available to provide for the needs of a severely disabled person. Trudy, to the end, never blamed her son for his behavior, nor did she think of him as a malicious or problematic person. Some adolescents who exhibit similar behaviors, however, are not so lucky, and do not have a kind and understanding parent who is willing to look past their behavior and see the good in them. Many parents, when faced with an even marginally difficult child, choose to outsource their parenting rather than commit themselves to raising their offspring regardless of the complications.

In troubled teen institutions, a staff member with no affective tie to a minor with behavioral problems is certainly not going to exhibit patience or understanding, especially when they are underpaid, overworked, and come into the relationship of dependency in a context of reforming a “troubled youth,” rather than seeking to understanding, as Simplican notes, the “why” in the violence. Simplican criticizes Kittay’s unquestioning endorsement of the need for transparency, or in other words, for a dependency worker to intuitively meet the needs of their charge while disregarding their

own needs. In the institutional dynamic, however, the charge's needs, even ones they state obliquely, are explicitly disregarded to "teach them a lesson." What then of the youth who lack the capabilities to express their needs verbally? This begets an even direr situation of neglect and abuse. Treatment centers like Discovery Ranch deal with "problem behavior" predominantly through means like isolation rooms or stress positions. While Kittay's proposal of transparency and troubled teen treatment centers' use of outright physical and psychological coercion and punishment fall at opposite ends of the spectrum of possibility, Simplican stresses the need to find a balance, in which the needs of the caretaker are expressed and acknowledged, and where care is distributed reasonably.

The factors that most powerfully pave the way for institutionalized abuse of the incarcerated include unequal distribution of power and a high visibility of power structures, as well as the environment of the institution itself, rather than those who reside within it. Essentially, disabled and institutionalized teenagers are trained to stay helpless so that they never leave institutions by instating "learned helplessness," which not only exacerbates existing impairments, but also cultivates a potentially deadly inability to function in the "outside world". Rather than teenagers being encouraged to develop into autonomous and self-sufficient adults, they are trained to be completely reliant upon the staff who monitor them constantly. This becomes extremely taxing for staff, who are put into unending custodial roles, rather than experiencing the positive affirmation of seeing the effects of successful care via the thriving and growth in their charges. Residential treatment staff's performance is predicated on their ability to maintain this powerlessness

and static subservience, rather than on their ability to perform effective and positive dependency work that is mutually fulfilling for both parties.

In Rifkin's examination of "Chelsea Girls," Kittay's theory of dependency ethics is extended and expanded from a location within a patriarchal marriage to an alternative mode of kinship that does not involve a breadwinner at the top of the hierarchical chain, so to speak. This alternative mode of dependency work is important to note, in that it affirms that the location of Kittay's dependency worker/charge relationship can exist in many locations, including within institutions. Rather than laying out how a caretaker should feel and behave, "Chelsea Girls," it seems in this review, paints the nitty gritty picture of the realities of dependency work, while adding the important dimension of potential skills and knowledge dependency workers can gain from their charges, rather than just ambiguous or nebulous sentimental benefits like affection and intimacy. Rifkin's work, in conjunction with that of Kittay's writings, shows how a case where a charge functions pedagogically in relation to his care giver, acting as a mentor and guide, rather than a custodian. This juxtaposition between Kittay's model and the alternative empirical example of Myles's experience shows that despite a charge's debilitating conditions that necessitate constant care, they can still offer concrete skills and benefits that exist outside the inherent dynamic of dependency worker and charge. Kittay's examples focus on benefits that are solely rooted in interpersonal connection, whereas Myles reinforces the independently generated benefits that arise from a charge's talents and skills, which emphasizes and preserves the dependent figure's individual worth and humanity, rather than situating them as an object to be acted upon, or conversely, a person whose needs are idealized and exaggerated to such an extent that they supplant the

needs of the dependency worker. This examination yields the realization of how important mutual respect and valuation can be in a relationship that includes a marked power hierarchy. Were the humanity and worth of troubled teenagers emphasized and affirmed to the staff to begin with, institutionalized abuse would be far less likely to occur.

Behavior modification via “tough love” has no empirical, scientific evidence to support its efficacy; rather, it is promoted purely through anecdotal evidence, conveniently picking and choosing which feedback from parents and children who have experienced the programs to use (Szalavitz, 378). By depriving individuals of basic autonomy as an answer to their deviation from a normative image of the able-bodied individual, the institution often exacerbates, or even creates, the problem of impaired functionality that it claims to “cure”. Conflating mental healthcare with behavioral reform ignores the suffering and difficulty inherent to neurodivergent life, and fails to nuance the impact of such on “bad” or “socially unacceptable.” With this conception of mental disability perpetuated within institutional settings, there is little hope for dependency worker staff to not only function effectively, but also to experience a safe and fulfilling work environment. On that note, however, the one thing every “troubled teen” in these programs has in common is the existence of a parental motive to send them there to begin with. Most these cases involve serious behavioral problems that impact not only the teenager in question, but also their parents- sometimes to the point of hopelessness and despair. This begs the question of what needs to be done in such cases. How can disruptive or socially unacceptable behavior be managed in an ethical way? Rather than institutions, mutually respecting and rewarding mentor relationships could be the answer.

Stacy Simplican posits a hopeful alternative to how life decisions are made for those who cannot make them themselves, which I believe should include minors. Planning Alternative Tomorrows with Hope (PATH)'s methodology of using a "multiplicity […of] perspectives to emerge […] around the focal person" includes community members, friends, teachers, and neighbors in the decision-making process, which is especially useful in cases of parental abuse or neglect that might prompt such outsourced parenting initiatives" (Simplican 227). Kittay states, "Dependency is an inescapable state of being, yet how young/sick/old one needs to be to be dependent is culturally determined, rather than by will or desire. It is central in human relations, and its vulnerability impacts moral obligations, which has repercussions on social and political organization." Ultimately, this proposition is not useful in this incidence, because it lays out an idealistic set of guidelines for how dependency workers must treat their dependent charges that ignores the reality of how taxing such work can be. Rather than isolating good caretakers by requiring them to meet near-impossible standards, it is more important to implement reasonable standards of care, especially within youth institutional settings, that function as protective measures against abuse and human rights violations by granting charges more autonomy and prohibiting totalitarian control at the institutional level.

Shame and Sexuality

Of all the reasons kids are sent to this brand of residential treatment centers, using sexual orientation to legitimize this breed of social exclusion, isolation, and confinement is the most obliquely wrong. This treatment is inherently more likely to occur not only because of the isolation that is intrinsic to the very nature of the institution, but also

because of the societal views that dehumanize residents. Szalavitz references a number of incidences of gender-specific torment at Straight, Inc.: "a girl who had recently had an abortion was made to dress up as though she was pregnant. A lesbian had told me she was regularly made to dress in heels and skirts in an attempt to "cure" her sexual orientation. And I'd heard many other such stories" (Szalavitz, 308). Unlike mental illness, behavioral problems, or addiction, the majority opinion in America does not condone "treating" or "fixing" homosexuality, let alone by using "tough love" or "any means necessary."

> Conversion therapy is "a set of practices that intend to change a person's sexuality or gender identity to fit heterosexual or cisgender standards and expectations — and it is usually religiously motivated. […]Conversion therapy causes serious harms," the National Center for Lesbian Rights Legal Director Shannon Minter told The Huffington Post. "In the short-term, queer youth who go through conversion therapy are being cheated of the opportunity to gain self-confidence and self-esteem, to get support from family members and other adults, and to have normal adolescent developmental experiences around friendship, dating, and other social experiences. In the long-term, the negative health consequences of being subjected to conversion therapy are extremely serious and can include substance abuse, dropping out of school, HIV infection, depression, and suicide attempts." (Nichols)

While the public conception of "conversion therapy" or "reparative therapy" tends toward the widely-publicized use of electroshock variety, these cases are few and far between in comparison to the sheer volume of LGBT teens who are incarcerated in "residential treatment centers" and subjected to psychological, physical, and emotional abuse intended to reshape them into a version of themselves that appeals to religiously motivated program administrators and that warrants parental approval. This in and of itself fits the standard definition for the debunked practice of attempted conversion therapy. The APA put forth the following statement in regards to this practice in 2009:

> "[…] Homosexuality per se is not a mental disorder (APA, 1975). Since 1974, the American Psychological Association (APA) has opposed stigma, prejudice,

> discrimination, and violence on the basis of sexual orientation and has taken a leadership role in supporting the equal rights of lesbian, gay, and bisexual individuals (APA, 2005). APA is concerned about ongoing efforts to mischaracterize homosexuality and promote the notion that sexual orientation can be changed and about the resurgence of sexual orientation change efforts (SOCE)[1][…]. Some individuals and groups have promoted the idea of homosexuality as symptomatic of developmental defects or spiritual and moral failings and have argued that SOCE, including psychotherapy and religious efforts, could alter homosexual feelings and behaviors (Drescher & Zucker, 2006; Morrow & Beckstead, 2004). […] Psychology, as a science, and various faith traditions, as theological systems, can acknowledge and respect their profoundly different methodological and philosophical viewpoints. The APA concludes that psychology must rely on proven methods of scientific inquiry based on empirical data, on which hypotheses and propositions are confirmed or disconfirmed, as the basis to explore and understand human behavior (APA, 2008a; 2008b).

Thus, virtually no programs openly advertise sexual orientation as something that they can "fix." Nonetheless, the bulk of evidence indicates that this practice is widespread within the troubled teen industry. A survivor with whom I connected, Amber Haynes, gave me the following testimony that reveals the unadvertised pejorative and homophobic principals held by that the WWASP-affiliated program she attended:

> "I attended Carolina Springs Academy in Donalds, SC. I was there from August 14th of 2001 to March 1st of 2003. My family didn't know about my being bisexual before I went. When I wrote the mandatory confession letter home I told them. This resulted in me getting a Manipulation correction. My family rep. Grace Contreras told me I was trying to scare my family into pulling me out of the program. Grace was also the one that told me and a few other girls we weren't allowed to be gay or bisexual. In the program, we could only be straight. She went on to say if we still claimed to be gay or bisexual we would be sent to one of the high impact programs in Costa Rica or Jamaica. As far as their services advertised, not even close to what I received. […]"

In this instance, Amber's parents did not elect to send her away on the basis of her sexuality, yet she was subjected to behavioral reform that attempted to punish her for being anything but heterosexual.

Even if the discrimination and abuse LGBT youth experience at the hands of staff isn't coded explicitly as conversion therapy, the combination of being sent there

specifically for that reason and experiencing a mode of "behavior modification" that is used for addiction treatment to achieve sobriety or abstinence affirms the existence of this under-the-table service. The Pride LA reported on the success of the Lara Bill's passage in California, and explicitly referenced troubled teen programs in describing where this conversion therapy occurs:

> "Nonetheless, unconscionable "troubled teen" camp promoters use "reparative therapy" as bait for fundamentalist religious families and if something goes wrong, or if their abusive methods are exposed—they simply pick up stakes and move to another location, perhaps under a different name to avoid the law, upset parents or creditors. [….] Los Angeles LGBT Center CEO Lorri L. Jean said in a press release. […] No longer can these programs—many of which claim to be Christian-based—hide behind their cross, asserting religious exemption to continue torturing LGBT youth they claim they can 'cure.'" (Ocamb)

Gay Shame opens with an examination of the limitations of the gay pride movement: "Liberation, legitimacy, dignity, acceptance, and assimilation, as well as the right to be different: the goals of gay pride require nothing less than the complete destigimatization of homosexuality, which means the elimination of both the personal and social shame attached to same-sex eroticism." (Halperin and Traub 3). How does one eliminate personal shame within an environment wherein this destigmatization is impossible? One of the critical failings of gay pride as an ideology is that it fails to consider the very real shame that many LGBT people are still made to feel, especially within communities wherein they have no access to a collective affirmation of identity. The isolated, pastoral troubled teen institutions epitomize both this circumstance, wherein there is no access to pride, and they also house youth whose comorbid behavioral or psychological problems might make them figures of whom the gay community cannot be proud: "Just as leading lesbian and gay political organizations continually struggle to present to the world a dignified and respectable image of homosexuality, so lesbian and

gay researchers have often been reluctant to delve into topics that risk offering new opportunities for the denigration and demonization of homosexuality" (Halperin and Traub 11). Troubled youth precisely exemplify the category of these unwanted individuals.

In Gay Shame, Heather Love notes that "while over the last 20 years activists have successfully turned shame against seemingly shameproof institutions such as the health care industry, we are often reminded how easily shame can be turned back and used against the shame prone" (Love 257). Programs use shaming tactics in this exact manner to exert control and maintain order. Shame is just one of many techniques to control the subjects in programs' care. A 2016 Huffington Post article tells the story of "TC, a 19-year-old gay man […who] was subjected to conversion therapy in 2012 when he was 15 years old after his parents discovered he was gay […] The first step — which usually lasted six months — [is] where they "deconstruct us as a person. Their tactics still haunt me. [...] They retaught us everything we knew. How to eat, talk, walk, dress, believe, even breathe. We were no longer people at the end of the program. They were able to turn us against ourselves," he said. "This is what drew so many people to suicide. We all shared a sense of loathing towards who we were and who we loved. It wasn't just your regular 'I hate myself.' It was a disgust with the person you were and you wanted to do anything you could to change" (Nichols). Love notes the "tenuous" ability of shame to bring those it touches together as a mobilized community in order to impact change. The isolating principle of this affective weapon poses a barrier to activism and self-advocacy, as shame tends to polarize individuals who it impacts, rather than cultivate shared identity and camaraderie.

Merri Lisa Johnson notes that "Queer theory and disability studies are hardly strangers to each other these days. The past decade has seen important work emerging from the intersection of the two fields […] Yet the work of this dialogue has been rather one- sided, with crip theorists making overtures and remaining politely unsatisfied with queer theorists' openness to the relationship" (251-252). She critiques the widespread notion that mental illness, including Borderline Personality Disorder, is a disqualifying factor for "epistemic knowledge." This disqualification is predicated on the failure that is part and parcel to psychiatric disabilities, due to the antisocial behavioral symptoms that accompany such a marker of difference, including negative coping mechanisms like self-harm and substance abuse. Johnson proposes a new schema to read these failures: "The bad romance model introduced in my opening is a useful heuristic for defusing this set of anxieties by refocusing from the individual person to the dynamics of relationships and invalidating environments, translating a discourse of blame that might point to my hypersensitivity as the problem into a discourse of mutual responsibility for fair and productive communication" (Johnson 261). Rather than rejecting those who exhibit such failures, the symptomatic results of psychiatric disability should factor into discussions of the nature and mode of queer and disabled life. People who exhibit antisocial or self-harming behavior, including so-called troubled teenagers, should not be excluded from the dialogues of minority groups to which they belong.

Problematically, many of these teenagers might also have an unrelated condition that functions as the ostensible sole reason they are there, or conversely, they might experience sexual and gender-based discrimination and conversion therapy attempts outside of their parents' solicitation while incarcerated. Neither of these instances,

however, legitimize this subjugation. When I spoke with a survivor of a WWASP branded program, he gave me the following account:

> "Good morning, I have witnessed the administrators of Casa by the Sea demonstrate extreme hatred of LGBT students. Jason Finlinson and Dace Goulding in particular. There was one time I got pulled into the office, made to sit on a bucket of soap, and then harassed and finally dropped back to lower level because of an incident I let 2 lower levels self-report. They had been having an inappropriate relationship and came to me since they trusted me. I had them self-report. The anger Jason and Dace had, they were so upset I didn't run off and tattle since it would've gotten these kids sent to High Impact. I'll never forget Jason telling me he was dropping me because, "you never should have let them self-report, now we can't send these fags to high impact." It was like a personal insult to him. Needless to say, the 4 Mormons running the place when I was there were extremely homophobic. […] This would have been in early '01. It appeared to me that parents were sending their kids there for concerns about homosexuality but it was kind of an unspoken thing. My own parents were concerned about my sexuality on top of other issues I was having. The staff there seemed to enjoy their position to make any kid that was out miserable. CASA was definitely not a place to be anything outside the Mormon scope of "normal." […] My mother is mentally ill and was convinced an event that never actually happened was causing me to be gay so that's why I had turned to drugs. Then drugs were the convenient excuse to ship me off. In reality it was living with an unstable person and suburban boredom that led to my drug use. Feel free to use my real name. Erik Dunstan"

Here, drug use is used as an equal measure of condemnation to legitimize Erik's incarceration, along with his sexual orientation. Both factors are used by his mother as criteria to send him away, and both are coded as behavioral problems rather than distinguishing between a maladaptive coping pattern and an immutable characteristic. This account echoes countless anonymous voices posted on forums across the internet, most of which accounts focus on the way that shame was used as a tool to punish and police kids for expressing who they were in terms of their sexual orientation.

Conflating sexual orientation with the variety of behaviors that many programs use as justification to demonize teenagers not only reduces homosexuality to a medieval rendering of sinful perversion, but it also ignores the lack of autonomy and coherent

"choice" involved in addiction or mental illness to begin with. Neither of these conditions are elective ones. These conflations and moralizations in turn manifest in one concrete message to these youth: you are defined by your behavior and how we perceive it to be bad/shameful, and thus you are an inherently bad/shameful entity. This concept echoes how, in relation to the concept of Gay Shame, "Invoking a psychological literature about the origins of shame in the affective live of an individual, Sedgewick claimed that shame is "identity-constituting:" it is "a bad feeling that one does not attach to what one does, but to who one is" (Halperin and Traub 4). Programs implement an ideology that posits one's worth, or goodness/badness, directly upon behavior as it applies to their schema of acceptability. Behavior that is objected to is thus attributed not to any context or causality, but rather to the ambiguous notion of morality.

"Problematic Sexual Behavior"

Across the board, sexual activity by youth within these programs is the leading cause for punishment and abuse. Upon reading swaths of survivor testimonies, a common theme becomes clear: sexual behavior, or even behavior that is perceived to be sexually motivated including passing notes to, speaking in private with, or even looking at peers in a "romantically charged way" seems to be at the root of the starkest measures of abuse, most notably stress positions, food and sleep deprivation, and extended periods of time kept in isolation rooms. Due to the religious principles upon which most of these programs are founded, sex is vilified to the extreme outside the context of marriage, for heterosexual and queer students alike. In fact, many of the "research articles" cited by Ascent programs are studies related to marital infidelity- something that shouldn't apply to minors, in theory, yet it used as justification to condemn what they term "Problematic

Sexual Behavior," which is often pseudoscientifically abbreviated as "PSB" as if it were a clinical condition, as Stephen Schultz, director of the Redcliff Ascent corporation uses on his personal parenting blog in articles like The Relationship Between Shame, Teen Treatment, Dual Diagnosis and PSB**:**

> **"**This particular student has a history of being in previous treatment programs and sexually acting out at some of those programs. Each time he would be separated from the rest of the group, additional staff were brought in and the parents were asked to find another placement within 24-48 hours. This particular student has a low/average IQ and has been diagnosed with being on the spectrum. I got the call because this student, who is underage and is in another program, sexually acted out with a 20 year old. We had a good conversation and I'm sure the family is in good hands with their consultant. My purpose in sharing this message isn't to "armchair quarterback" this clinically complicated situation. It is simply to re-frame how we tend to think about Problematic Sexual Behavior (PSB) and how we can better discuss these issues with families when their teens are burdened with a problem.**"**

Put plainly, this anecdote describes a cognitively disabled minor's sexual relations with a 20 year old as "problematic sexual behavior" that needs to be corrected, rather than what both the law and common sense clearly indicate this situation to be: statutory rape of an individual with lower-than-usual defenses. Rather than persecuting this sex offender, the victim is instead placed in another punitive program for behavior modification for "sexually acting out." This blog post goes on to describe how said minor was placed at Oxbow Academy, an affiliate program of Redcliff Ascent that claims to treat both victims of sexual assault and teenagers who have committed sexual abuse, lumping these diametrically opposed conditions together as, again, "Problematic Sexual Behavior." This is victim-blaming in the most acute sense. Furthermore, Schultz's frequent references to anecdotal accounts of his "clinical experiences" with students at Oxbow contain a key omission: Oxbow exclusively treats males, thus all the vilified sexual encounters in which students are caught "relapsing" in their sexual addiction, or whatever other

ridiculous manner Schultz uses to code this, are queer ones. A particularly disturbing post on The Interpreted Rock shows Schultz lecturing to students at Oxbow using an appropriation of pedophilic terminology:

> "I am a partner in a specialty care facility called Oxbow Academy. Oxbow specializes in treating teenage boys from across the globe who are burdened with the socially sensitive concerns of sexual trauma, sexual abuse and sexual addiction. […] I started out asking the boys if they knew what grooming was. A few hands shot up immediately and I got answers like combing your hair and brushing your teeth. I mentioned that they were right and that hygiene is an important part of residential living. I then went on to mention that grooming is also a way for one student to set up a situation over time that leads to some type of sexual encounter with another student. Many of those attending had a blank stare. So, I went on to share with them that sometimes when they are involved in horse play or wrestling around, a particular student may grab them in the crotch or touch them in what feels like an inappropriate way. And then, when confronted, there is an instant excuse of, "… it was an accident, what are you talking about!" But, you kind of know that it wasn't. I also mentioned it can happen through nonverbal actions such as eye contact, passing notes, drawing pictures, giving gifts, flashing someone from the shower etc. Some in the room started to squirm a bit. Most students were now engaged in the conversation. […] Clinically significant sexual concerns thrive in secrecy. When there is open and honest education about language and behaviors concerning sexual issues, the socially inappropriate behaviors of those few high-risk students become exposed. Those few students then react in a stressful way. They, in essence, rise to the surface and can no longer hide. It was apparent that these two students needed further attention and evaluation. When talking with the residential staff, they already knew those two boys were "outliers" from the rest of the population. Neither of these responses was due to trauma, it was a reaction to future secrecy and manipulation being disrupted. It was a response to their peers now knowing their secrets."

Terming this type of behavior "grooming" equates consensual interactions with sexual assault. Homosexual encounters between consenting and equally aged male minors are absolutely distinct from predatory adults committing pedophilic sexual assault. This demonization of queer encounters brings the stigmatized trope of the predatory or pedophilic adult gay man, one so often used to the advantage of homophobic bigotry, and applies the surrounding sentiment to egalitarian encounters between minors

that are not predicated on power differences, and thus not inherently harmful. This linguistic coding of gay male interactions demonizes natural behavior to a terrifying degree.

Troubled teen residential programs are integrally predicated on cultivating unbearable feelings of shame for the purposes of increasing vulnerability and dependency, and decreasing autonomy and self-advocacy. Program staff and officials wield this weapon from a multiplicity of angles. Primarily, entry into the program instates the shaming label of being a "troubled teen," regardless of what specific problem is theoretically being treated. This blanket title serves to both amplify preexisting stigmas on disability and sexuality, and to create an entirely new category of subjugation and exclusion that conflates elective behaviors with inherent facets of identity and selfhood, ultimately moralizing and condemning things over which teenagers have no choice. The shame of being "unwanted by one's parents" and implicitly by societally at large is often invoked as a mechanism of control. There's no point in running away, kids are told, because no one would aid or assist a "troubled teenager:" thus, the program is implicitly the only place they can stay. Many youth who "age out" of the programs, once they turn 18 and are legally able to refuse care, have no avenue to a new life, and without any financial support or way to get home or contact people who might help them, end up homeless. Local residents are primed by programs to not only return these youth back to the program if they ask for help, but also to not believe anything these "bad, manipulative, troubled teenagers" say to begin with.

Approaches to Healing

Trauma Theory

Trauma theory seeks to examine the ways in which conditions like PTSD impact the quality of life for survivors of horrific events. The main obstacles to healing arise from the inherent difficulty of not only being listened to and testifying to one's unspeakable experiences, but also from the monumental struggle of understanding these events and integrating them into one's life and sense of self. Therefore, the pain of

trauma is rooted not only in the fear of others not believing or hearing one's experience, but also the sense of uncertainty and doubt that fragmented memory can manifest. Proper treatment for trauma necessitates the opportunity to testify to one's experience both internally and externally, as well as guidance in integrating the fractured self. Cathy Caruth's Listening to Trauma puts forth a series of interviews with leading theorists and practitioners, and the overviews of their work function to posit an effective method of treatment for survivors of trauma that prioritizes healing their psychic wounds over blaming them for their symptomatic behavioral responses.

Trauma survivors feel an urgent need to survive in order to tell their story. So, too, it their ability to survive also predicated on obtaining this opportunity, "unimpeded by the ghosts of the past" that once silenced their voices. Dori Laub is a psychoanalyst who has specifically focused on Holocaust survivors and the role of testimony, historical erasure, and bearing witness as theory and treatment. Laub's linguistic choice of "ghosts of the past", coupled with how bearing witness is "haunted by impossibility," invokes a language of the supernatural as allegory which speaks to the intangibility and doubt that plague trauma survivors who try to tell their stories. The dyadic approach troubled teen programs take of attributing a former resident's success in life to the program, while personally blaming others for failures based on the criteria used to solicit their placement from the start, creates yet another barrier for humane treatment and basic human liberties for institutionalized persons. Patients not only do the incarcerated lack basic legal rights,

but they also face societal stigmatization from being incarcerated that invalidates their worth and silences their voice.

Stigma is an affective state that is still tied to social structures, specifically relations of power that position people on a hierarchy of goodness and worth, and manifests in both the internal perception of one's self as well as in external interpersonal interactions. This insidious phenomenon occurs whenever a human difference strikes at however a culture is defined. Due to the infinite variety of human difference, anything can become stigmatized, and thus which traits are at any certain time is cyclical. In this sense, stigma mirrors disability in that it "could happen to anyone." Ultimately, stigma manifests in both external and internal violence, imbuing a self-loathing born of an internalized negative sense of one's "lack of this or that," ultimately one's "lack of the normal." The ego becomes stuck in a self- regarding loop, begetting negative and damaging reactions to one's self or others, in response to the dilemma of difference when a value judgment is placed upon deviating factors. Stigma, in turn, is among many things "a set of personal and social constructs; a set of social relations and social relationships; a form of social reality" that Lerita Coleman Brown theorizes to be "arbitrarily defined," and culturally and historically contingent upon the perception of human differences, and is defined by the majority: "those possessing power, the dominant group, can determine which human differences are desired and undesired" (Brown 141). Stigma often arises from the fear of things that humans don't have the means to quantify or understand, which generates the conception that symptoms of mental illness represent personality, morality, or intelligence. This conflation is exemplified by program's use of the troubled teen label to encapsulate a variety of human differences ranging from disability to

sexuality. While Brown asserts that physical abnormalities are the most stigmatized, majority group, neurotypical people equally fear the behavior that results from mental illness. Behavior itself is an integral mode of forming interpersonal connections. Such relation becomes incredibly hard when mentally ill, precisely because the fear of others' perception is inherent to such type of cognition, creating a vicious cycle in which inordinate distress and worry about what people think spurs behavior that does, in effect, make them think negatively.

Maia Szvalavitz elucidates the bottom line of how this industry avoids prosecution and public scrutiny in her 2004 exposé Help at Any Cost: How the Troubled Teen Industry Cons Parents and Hurts Kids, "[a]fter all, if these kids told the truth, they wouldn't need to be in the program, would they?" (Szalavitz,18). Not only do these incarcerated youth lack basic legal rights, but they also face societal stigmatization from being "sent away" that invalidates their worth and damages their credibility. Coupled with the fact that programs allow little to no contact between parents and children, with most programs openly advertising a minimum of weekly observed phone calls or written letters, the inability to report abuse that goes on leads to lengthier stays, especially when the communication about "how the child is doing" comes primarily from the institution itself. This lack of access to communication is clearly widespread enough to merit a clause in this year's Senate Bill 3031:

> (E) ACCESS TO COMMUNICATIONS.—Each child at such a program—(i) shall have reasonable access to a telephone and means for electronic and written communications, and be informed of the child's right to such access, to maintain frequent contact with parents or guardians, including making, sending, and receiving scheduled and unscheduled calls, unrestricted written correspondence, and electronic communications, with as much privacy as possible; and (ii) shall have access to current and appropriate national, State, and local hotline numbers for reporting child abuse and neglect."

Imagine being in this situation and not even being able to tell your parents what's going on. Now imagine having to tell them that everything is fine, because your abusers are sitting next to you, watching you talk with them on the phone, reading to hang up if you say one word out of line.

While children are there, they can neither talk freely with their peers nor communicate openly with their parents, and complaints are rejected by staff as lies or manipulative behavior. They have no one, while they are there, to bear witness to their suffering even as it occurs.

Dori Laub's work outlines the necessary circumstances for witness, which requires a totally present listener in an appropriate space: the survivor needs both an external and an internal companion. The survivor is not just telling a story that already exists, but rather, the listener must put fragments together as a whole, present that whole to person telling, and they either agree or disagree. Thus, the ego must be restructured in order to create in internal addressee, for whom the therapist can function as a temporary stand in. Laub notes that many psychotic patients were extremely motivated to testify, yet found themselves unable to do so when the time comes. It was initially impossible for them to relate their experiences because they lacked the adequate internal conditions. The eternal emotional and psychological consequences of trauma can't be conveyed through pictures or film, which often does not even exist as a corroborating resource. A lack of objective documentation is just one of the many obstacles survivors must overcome in

order to bear witness, because the onus of doubt projected upon them by others is internalized and manifests in uncertainty and invalidation.

Art Blank, who began his career as a psychiatrist in Vietnam, was one of the first in his field to acknowledge the effects of trauma on soldiers, as well as establishing some of the guidelines with which it came to be treated within the Veterans Administration. His work was crucial to informing the diagnosis of PTSD as it appeared in the DSM III-R and DSM-IV. He established these diagnostic criteria by using Otto Fenichel's Psychoanalytic Theory of Neurosis from 1945, rather than the DSM-I. The anti-war sentiment was a huge obstacle to productive work on Vietnam Veterans. Art Blank terms this a "psychiatric propaganda campaign," in which PTSD was referred to as "combat fatigue/neurosis/exhaustion" or patients were labeled as having schizophrenia, panic disorders, alcoholism, and other conditions that ignored the root cause of their suffering. Former patients of troubled teen programs who experience PTSD, form negative coping strategies to deal with the trauma they incurred while detained, and ultimately struggle to succeed in their education, careers, and personal lives as a result of their treatment are framed as "not credible sources" precisely because of these failures and struggles. Their credibility is damaged not only because they were labeled as troubled teenagers before they even stepped foot into a program, but also because these programs damage their mental health and wellbeing to such a profound extent that they lack both the resources and social status to seek retribution.

Misdiagnosis, which has so often confused PTSD for alcoholism, substance abuse, depression, mood disorder, and schizophrenia, led to over-medication that did not effectively treat the real problem, and often made it even worse. Implementing the

framework of PTSD as a diagnosable condition enabled effective research, new treatment methods, and a better understanding of patients. Traumatic memories, rather than fading or reforming into something productive, refuse to turn into a mere story from the past. Unlike veterans, abused children struggled to recover particularly when they remained in the care of their abusers, rather than enemies at war.

The voices of children in troubled teen programs are profoundly silenced, in turn, not only by the credibility they lack upon the basis of their placement, but also due to the devastating conditions in which many find themselves. Szalavitz cites a court case in which "a parent who even claimed that an earlier-stage program called Straight, Inc. (a personal favorite of Nancy Reagan in her campaign in the war on drugs) was effective, revealed that her kids were 'homeless', 'refusing bipolar medication', and 'heroin addicts': neither of whom had consumed any drug other than marijuana before their stay" (Szalavitz, 234). Art Blank felt "the silence of coming home" was part of the trauma itself, but by popular opinion, talking about it was thought to make it worse. This reticence to discuss the war exclusively protected those who didn't want to know about the situation. Like the obfuscation of the nature of troubled teen programs, Vietnam was an "invisible war," even within the field of psychiatry, and soldiers experienced traumatic events that were later complicated by others' refusal or inability to understand or accept what they had been through. A record was in place at institutions that treated, but was going unrecognized, and no one was making the link between veterans' symptoms and war trauma. Similarly, former residents of troubled teen programs span a vast range of destitute and disabling conditions that are not attributed to the root cause of their trials and tribulations later in life.

After children are free from the confines of these programs, unless conditions that facilitate healing are put in place, not much can change. Despite the fact that many parents truly don't know what goes on while their children are detained, they are often unmotivated to press charges for something that they ultimately solicited and paid for, if they even believe their children. Furthermore, the statute of limitations for these cases is 2 years in Utah. Since minors generally lack the resources to file lawsuits independently, and since many survivors take years to even begin to be able to process and disclose what they endured, even if they receive a supportive and affirmative response from their parents it is often too late to take any legal action. Those who do risk defamation lawsuits, to which they are particularly vulnerable since it's difficult to obtain supporting materials like staff records, which would have to be procured by the offending institutions, to corroborate their accounts.

Community Building for Survivors

All of the above factors present steep obstacles to being listened to, understood, and heard. Furthermore, as the abuse in residential treatment centers is a widespread issue, there also exists a component of guilt and culpability in not speaking out. This was not an isolate or aberrant event of trauma and abuse. It is extremely widespread and ignored. Racheal's work, therefore, is not only a powerful form of therapy on a personal level, but also a crucial representation of a hugely important and shrouded phenomenon. In the forward to Black Eyes, Rachael asserts "[that] this [book] is for the survivors and the warriors. The ones who fight with their demons and take back their night. This is for the silenced and the oppressed, this is for me and most importantly for you." Since it's difficult to get in touch with fellow residents after the fact, as it's often prohibited to

exchange contact information, online communities are one of the few resources available to find others who have experienced these types of programs.

Over the course of this research, it's been exceedingly difficult to connect with survivors of these programs. The best resources available seem to be a very active subreddit (r/troubledteens) and dedicated private Facebook groups where survivors can communicate with one another about their experiences. One such group, WWASP survivors, was very useful for finding people who wanted to discuss their negative experiences for me. Interestingly, the dialogue within these groups comes in waves. There will be intense periods of discussion, along with regular attacks on members by those who believe the program helped them, often ridicule about "getting over it" or "not having a life." Many people don't want to talk about it. Some people who were sent to these programs believe that the program helped them so much that they decide to work there when they are young adults, and subject current residents to the same treatment they received. Perhaps this is due to the desire not to know, an impulse that protects survivors of trauma from engaging with their pasts fully. In Dori Laub's work, screen memories, which shielded survivors from the extent to which they suffered and functioned as a protective coping mechanism, had to dismantled to get to the survivor's truth. This truth was "a record that has yet to made," stuck inside of them in a fragmented and incomplete turmoil. Furthermore, he notes that overcoming the death drive, which is against knowing and the development of knowledge, was a crucial measure. Denial and

compartmentalization can work as coping strategies to combat PTSD, albeit temporarily and ineffectively.

A common theme within survivor group narratives are periodic calls to action imbued with a sense of urgency, after which these same commenters may disappear for a while. Many members have difficulty advocating for themselves or securing the care they need to heal. Trauma interrupts the linear narrative of life. In The Body Keeps the Score, Bessel Van Der Kolk relates a case study in which a veteran relates his experience of PTSD, including constant anger and maltreatment of his family, alcohol abuse, reckless behavior, nightmares, and flashbacks, and insomnia. In therapy, he expressed his fear and feeling of being out of control. When Van Der Kolk prescribed him medication, he refused to take it because he felt blocking out these nightmares and flashbacks was a betrayal to his lost comrades, saying, "I need to be a living memorial to my friends who died in Vietnam." In his mind, his experience at war "rendered the rest of his life irrelevant," and he was "frozen, trapped in a place he desperately wanted to escape." Vietnam veterans, lacking sufficient access to trained professionals, were often arrested for violence, drunkenness, and many committed suicide. When they began treatment, they generally first refused to talk about what happened, but ultimately that was all they talked about when they began sessions. The temporary talk therapy groups functioned as a place to find resonance and meaning in tragedy. However, individual current experiences did not prove conducive to group therapy. They only felt fully alive when reliving their traumatic experiences. This mirrors the overwhelming sentiment that many of these online communities convey. Ultimately, however, community building is a

difficult thing to accomplish since so much of the psychological ramifications of these programs are designed to preempt solidarity.

Art as Therapy

Terry Rizzuti, a Vietnam war veteran, has articulated an alternative mode of bearing witness: the power of writing as therapy. By creating an account of his war trauma that he terms “The Puzzle,” he takes control of the narrative of his life, rewriting the convoluted past that formerly violated and controlled him via flashbacks by consciously and voluntarily putting it in his own words. In terms of his struggle with the obstructive daily ramifications of the trauma he experienced, he notes “I remember when I came home from Vietnam, everyone kept asking me what the experience was like. Part of me, a big part, didn’t want to talk about it, but in reality, I had no clue how to talk about it”. (386) Rizzuti was unable to write about his experiences until 18 years after the war. Rachael McAllister, whom I met at Discovery Ranch in Utah, and who suffered the same abusive measures as I did while there, recently published a book entitled Black Eyes. Both of us experienced a year of extreme trauma almost a decade ago, and took about the same number of years to not only talk or write about our experiences, but also to autonomously recall and accept the reality of what happened to us. It is this extended period of self-doubt, pain, and confusion that extends long beyond leaving that ultimately makes the experience of institutionalized abuse so unbearable. Laub gives a bodily representation to the pressure to testify, as an “innate instinct” that drives one to deal with, shape, and manage experience. He uses the image of a wound, the Greek etymological meaning of the word “trauma,” as metaphor. Just as a wound is a physical proof of having been hurt, a wound generates its own bodily process of healing and

creating new cells and taking a concrete shape, yet only within the right conditions (Laub notes sterility and temperature), and thus the healing process functions as a concrete event just as tangible as the traumatic experience.

Dylan Scholinski, who was confined to a psychiatric ward for three years for being transgender, uses painting as a means of recovery: "I paint for my survival and for myself. Time and again, I have realized that without my art, I would likely be dead. […] I consider all of my art to be autobiographical. I tell stories about my life: what I am thinking, feeling, experiencing, creating a map of living and breathing emotions. I rarely hold my breath in painting- unlike in real life, where the simple process of breath, the literal proof of my existence, poses a daily challenge. The content of my paintings deals with the experiences I had leading up to and during my years in the hospital and continues to reflect the struggles I face being transgendered, gay, human, as well as an ex-mental patient" (Scholinski 192). His work details his suicidal ideation that stemmed from the pain of being incarcerated based on an immutable facet of his identity, and he uses this aesthetic outlet to process his former life experiences.

Rachael's biggest struggle in overcoming the abuse she experienced is the fact that she was, and is, shamed into silence. Using abstract poetry and prose, she described to me a sense of relief and distance previously unavailable to her. By articulating her experience though artistic expression, she grasps the unrelenting memories and flashbacks that come at her in a way that is beyond her control, and she manages the feelings and emotions and pain that they incur. Black Eyes is not merely a way to vent, but also to find hope and manageability. It paints a visceral portrait of not only her personal life experience, but also the general experience of any child who is incarcerated

in one of these facilities. While a good deal of the writing is abstract and allegorical, much of the content is completely straightforward. Some of the most powerful moments in the work take the form of short, straight sentences. Equally moving to her description of picking up rocks and hiding under a wheelbarrow, this short verse elicits an emotional and evocative response:

"7 years later

almost free

PTSD

still

haunts

me" (36)

The structure of the line breaks and brevity of the prose mirrors the way affective responses to trauma is fractured and irregular. The imagery of being haunted is so accurate, and the way every word is on a new line mirrors the long-lasting effects of living with PTSD. Rizzuti states, "I discovered was that writing could add a layer of fiction between me and the actual experience, that that layer of fiction could create a buffer zone within which I could "play around" with the experience in ways that were therapeutic." (389) Rather than forgetting, it seems like expression and rewriting the narrative with an uncensored voice is far more effective in striving to mitigate the impact of trauma and progress to catharsis. In our case, a huge component of the trauma was constant surveillance and censorship. Writing and expressing our experience, one we

were never able to voice or react to at the time, is thus especially well suited as a therapeutic means to recovery.

Conclusion

There are virtually no adolescents who do not struggle at times with the process of growing up. Parental conflict, defiance, and rule-breaking are all standard and to be expected during these developmental years. In the case of adolescents who do struggle with mental illness, cognitive or physical disability, or substantial behavioral problems, there are myriad options to provide at-home care. Rather than placing minors in facilities that will traumatize them and exacerbate problems they might have for years to come on the basis of fear and "what-if" speculation, it is necessary for caretakers to seek individualized care at the community level, and also to take into account their own role in family dynamics. The due process of law exists to protect individuals from abuses from those in positions of authority. Simply being a minor should not reverse the "innocent until proven guilty" model of culpability. Unfortunately, institutionalized child abuse is not an independent phenomenon. Until stigmatization of non-normative individuals is eradicated at the level of social consciousness, this treatment will continue in its vast, immeasurable permutations. Simply being a minor should not reverse the "innocent until proven guilty" model of culpability and incarceration. Being different, especially when that difference involves suffering, is not a crime.

References

All Kinds of Therapy. "Can Your School System Help with Treatment Options? 8 Questions to Ask." All Kinds of Therapy. Family Choice Behavioral Healthcare Interventions, 31 Mar. 2017. Web. https://www.allkindsoftherapy.com/blog/can-your-school-system-help-with-treatment-options--8-questions-to-ask-

Alliance for the Safe, Therapeutic & Appropriate Use of Residential Treatment. Stop Abuse in Residential Treatment for Troubled Teens. Troubled Teen Industry: Help or Harm?

Anton, B. S. (2010). Proceedings of the American Psychological Association for the legislative year 2009: Minutes of the annual meeting of the Council of Representatives and minutes of the meetings of the Board of Directors. American Psychologist, 65, 385–475. doi:10.1037/a0019553

"Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts." American Psychological Association. American Psychological Association.28 Apr. 2017.

Bagenstos, Samuel R. “The Projects of the American Disability Rights Movement: Law and the Contradictions of the Disability Rights Movement. Yale University Press. (2009) Stable URL: http://www.jstor.org/stable/j.ctt1npkj3.5

Brown, Lerita Coleman. "Stigma: An Enigma Demystified." The Disability Studies Reader. 4th ed. New York: Routledge, 2013. 142-53.

Caruth, Cathy. Listening to Trauma: Conversations with Leaders in the Theory and Treatment of Catastrophic Experience. 2014.

Clifford Simplican, S. Care, Disability, and Violence: Theorizing Complex Dependency in Eva Kittay and Judith Butler. Hypatia, 30: 217–233. 2015.

"Clinton Dorny." Discovery Ranch Teen Residential Treatment Center for Boys.

Congressman Adam Schiff. Reps. Schiff and Ros-Lehtinen Introduce Bipartisan Legislation to Reform Residential Treatment and Youth Boot Camp Programs | U.S. Congressman Adam Schiff of California's 28th District. Representing California's 48th District. 14 July 2015.

Consequences of Sex Addiction." Discovery Ranch. The National Council on Sexual Addiction and Compulsivity.

Falchuk, Brad, and Ryan Murphy. "Welcome to Briarcliff." American Horror Story: Asylum. FX. Los Angeles, California, 17 Oct. 2012. Television.

“FAQ." Discovery Ranch Teen Residential Treatment Center for Boys. Redcliff Ascent.

Diagnostic and Statistical Manual of Mental Disorders: DSM-IV. Washington, DC: American Psychiatric Association, 2000.

Foucault, Michel. Discipline & Punish: The Birth of the Prison (NY: Vintage Books 1995) pp. 195-228

Fritzlan, Larry. "How to Drug Test Your Teen." Discovery Ranch Teen Residential Treatment Center for Boys. Adolescent Recovery Services, 2007.

Gilman, Charlotte Perkins, and Dale M. Bauer. The Yellow Wallpaper. Boston: Bedford, 1998.

Gorski, Terrence T. "Post Incarceration Syndrome and Relapse." The Addiction Web Site of Terence T. Gorski. The CENAPS Corporation.

Halperin, David M., and Valerie Traub. Gay Shame. Chicago, IL: U of Chicago, 2009.

Harrison, Kathryn. "Who Is the Real Savage?" The New York Times On the Web. The New York Times Company, 1998

“Helping Teens and Families." Discovery Ranch Teen Residential Treatment Center for Boys.

Kittay, Eva. Dependency and the Ethics of Care. Love’s Labor: Essays on Women, Equality, and Dependence. Routledge, 1999.

Johnson, M. L. (2015), Bad Romance: A Crip Feminist Critique of Queer Failure. Hypatia, 30: 251–267. doi:10.1111/hypa.12134

Johnson, M. L. & McRuer, R. "Cripistemologies: Introduction." Journal of Literary & Cultural Disability Studies, vol. 8 no. 2, 2014, pp. 127-147. Project MUSE, muse.jhu.edu/article/548847.

Jonas, M (06/01/1982). Patient Behavior in Hospitals: Helplessness, Reactance, or Both? Journal of Personality and Social Psychology. 42 (6), p. 1036. (ISSN: 0022-3514)

Kohlstaedt, Elizabeth. "Family Team Dynamics: An Intervention for Enhancing Reactive Functioning in Direct Care Staff in Children’s Residential Relational Treatment." Journal of Therapeutic Schools and Programs IX (2017).

McAllister, Racheal. Black Eyes. 2015.

Miller, John L., MD. "Alcohol Use Disorder." Discovery Ranch Teen Residential Treatment
Mitchell, David. "Institutionalization as "Alternative Lifestyle": Susan Nussbaum's "Good Kings Bad Kings"" Truthout. 08 Sept. 2013.

Mitchell, D. T. The Biopolitics of Disability: Neoliberalism, Ablenationalism, and Peripheral Embodiment. Ann Arbor: University of Michigan Press, 2015. Project MUSE.

Molnar, Beth E. "Juveniles and Psychiatric Institutionalization: Toward Better Due Process and Treatment Review in the United States." Health and Human Rights 2.2 (1997): 98.

Nichols, James Michael. "A Survivor Of Gay Conversion Therapy Shares His Chilling Story." The Huffington Post. TheHuffingtonPost.com, 17 Nov. 2016. Web. 28 Apr. 2017.

Nussbaum, Susan. Good Kings, Bad Kings: A Novel. Algonquin Books, 2013.

OAH Case No. 2014120525. In the Matter of PARENT ON BEHALF OF STUDENT vs. SAN DIEGO UNIFIED SCHOOL DISTRICT. (March 17-19, 2015)

"Overview." National Association of Therapeutic Schools and Programs. NATSAP, <https://www.natsap.org/Public/About_NATSAP/Overview/ImportTemp/Overview.aspx?hkey=faa851f9-cd6e-4f64-9a33-c97790bb635d>.

Plath, Sylvia. The Bell Jar. New York: Harper & Row, 1971.

"Program Staff Information." Heal-Online. Human Earth Animal Liberation, 8 July 2013.
RESIDENTIAL TREATMENT PROGRAMS Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth, Committee on Education and Labor, House of Representatives Cong. (2007) (testimony of United States Government Accountability Office).

RESIDENTIAL FACILITIES Improved Data and Enhanced Oversight Would Help Safeguard the Well-Being of Youth with Behavioral and Emotional Challenges, Chairman, Committee on Education and Labor, House of Representatives Cong. (2008) (testimony of United States Government Accountability Office Report).

Rifkin, Libbie “Say Your Favorite Poet in the World is Lying There”: Eileen Myles, James Schuyler, and the Queer Intimacies of Care.” Georgetown University.

Ross, Jamie. "Family Alleges Bestiality at Alternative School." Courthouse News Service. Courthouse News, 13 Feb. 2015.

Schneider, H. J. (03/1996). Violence in the Institution. International Journal of Offender Therapy and Comparative Criminology. 40 (1), p. 5 - 18.

Schneider, Jennifer P., and Deborah M. Corley. "Disclosure of Extramarital Sex." Discovery Ranch. Brunner-Routledge Publishers, 2002.

Schultz, Stephen C. "The Interpreted Rock." The Rocky Landscape of Teen Sexuality. Blogger, 02 Feb. 2016. Web. 28 Apr. 2017. <http://www.theinterpretedrock.com/2014/08/a-conversation-about-teen-sexuality.html>.

Simplican, Stacy Clifford. "Care, Disability, and Violence: Theorizing Complex Dependency in Eva Kittay and Judith Butler." Hypatia 30.1 (2014): 217-33.

Smith, Angela. "HEAL--Fighting for Human Rights, Animal Welfare, and Environmental Sustainability!" Human Earth Animal Liberation. 14 Oct. 2008.

Snyder, Sharon & David Mitchell. “The Eugenic Atlantic: Disability and the Making of an International Science.” In S. Snyder & D. Mitchell, Cultural Locations of Disability (Chapter 3)

Stapleton, R., Young A., & Senstock, T. (2016). Stress in direct care staff working in residential treatment centers. Journal of Therapeutic Schools and Programs, 8, 71-80.

Szalavitz, Maia. Help at Any Cost: How the Troubled-teen Industry Cons Parents and Hurts Kids. New York: Riverhead, 2006. Print.

---. "The Trouble With Tough Love." Washington Post. The Washington Post, 29 Jan. 2006.
"Troubled Teen Industry: Help or Harm?" Stop Abuse in Residential Treatment for Troubled Teens. Alliance for the Safe, Therapeutic & Appropriate Use of Residential Treatment, 2011.

United States of America. The U.S. Department of Justice. Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking. GET ANSWERS ABOUT SEXUAL ABUSE AND ASSOCIATED RISKS: Common Questions. By Nsopw. DOJ.

United States Government Accountability Office Testimony Before the Committee on Education and Labor, House of Representatives RESIDENTIAL FACILITIES State and Federal Oversight Gaps May Increase Risk to Youth Well-Being, House of Representatives Cong. (2008) (testimony of Kay E. Brown, Director Education, Workforce, and Income Security Issues)

United States Government Accountability Office Testimony Before the Committee on Education and Labor, House of Representatives RESIDENTIAL PROGRAMS Selected Cases of Death, Abuse, and Deceptive Marketing, House of Representatives Cong. (2008) (testimony of Gregory D. Kutz, Managing Director Forensic Audits and Special Investigations)

United States Government Accountability Office Testimony Before the Committee on Education and Labor, House of Representatives SECLUSIONS AND RESTRAINTS Selected Cases of Death and Abuse at Public and Private Schools and Treatment Centers, House of Representatives Cong. (2009) (testimony of Gregory D. Kutz, Managing Director Forensic Audits and Special Investigations)

U.S. Department of State. 7 FAM 1780 BEHAVIOR MODIFICATION FACILITIES. U.S. Department of State, 25 Mar. 2013. Web. <https://fam.state.gov/fam/07fam/07fam1780.html>.

Van der Kolk, Bessel A. The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma. New York: Viking, 2014.

Young, Michael C., and Michael Gass. "Integrated Risk Management Model for the Therapeutic Schools and Programs: Why the Risk Is Worth Taking." Journal of Therapeutic Schools and Programs I.II (2006):

Young, Michael C., and Michael Gass. "Current Descriptions of National Association of Therapeutic Schools and Programs (NATSAP) Members." Journal of Therapeutic Schools and Programs III (2008):

Zimbardo, Philip G. "The Mock Psychiatric Ward Experience." The Lucifer Effect by Philip Zimbardo. N.p., 2006.
---. "Stanford Prison Experiment." The Stanford Prison Experiment : A Simulation Study of the Psychology of Imprisonment.

Further Reading:

Senate Bill 3031, Stop Child Abuse for Teens in Residential Programs Act of 2016

Government Accountability Report

2016 Huffington Post Article by Sebastian Murdock:

http://testkitchen.huffingtonpost.com/island-view/troubled-teen-industry/

Work by Maia Szalavitz:

http://www.washingtonpost.com/wp-dyn/content/article/2006/01/28/AR2006012800062.html

http://www.motherjones.com/politics/2007/08/cult-spawned-tough-love-teen-industry

https://www.amazon.com/Help-Any-Cost-Troubled-Teen-Industry/dp/1594489106

Resources for survivors and parents include:

ASTART, the Alliance for the Safe and Ethical Use of Residential Treatment

CAFETY, Community Alliance For the Ethical Treatment of Youth Facebook & Twitter

SIA, Survivors of Institutional Abuse

Safe Teen Schools

HEAL, Human Earth Animal Liberation's Teen Liberty campaign

Universal Health Services Behind Closed Doors

Survivor Testimonies on Reddit, Fornits, WWASP Survivors, Surviving Straight, Inc

HIGHLIGHTS: **Senate Bill 3031: Stop Child Abuse in Residential Programs for Teens Act of 2016**

(a) Minimum Standards.—
(A) PROHIBITION ON CHILD ABUSE AND NEGLECT.—Child abuse and neglect shall be prohibited.
(B) PROHIBITION ON CERTAIN DISCIPLINARY TECHNIQUES.—Disciplinary techniques or other practices that involve the withholding of essential food, water, clothing, shelter, or medical care necessary to maintain physical health, mental health, and general safety, shall be prohibited.
(C) PROHIBITION ON PHYSICAL OR MENTAL ABUSE.—Acts of physical or mental abuse designed to humiliate or degrade a child, or undermine a child's self-respect, shall be prohibited.
(D) LIMITATION ON RESTRAINTS AND SECLUSION.—
(i) CERTAIN RESTRAINTS AND SECLUSION.—The use of seclusion, mechanical restraints, and physical restraints that impair breathing or communication shall be prohibited.
(E) ACCESS TO COMMUNICATIONS.—Each child at such a program—
(i) shall have reasonable access to a telephone and means for electronic and written communications, and be informed of the child's right to such access, to maintain frequent contact with parents or guardians, including making, sending, and receiving scheduled and unscheduled calls, unrestricted written correspondence, and electronic communications, with as much privacy as possible; and
(ii) shall have access to current and appropriate national, State, and local hotline numbers for reporting child abuse and neglect. .
(P) INFORMATIONAL MATERIALS.—Full disclosure, in writing, in promotional and informational materials produced by a covered program, shall be given to parents or guardians of children at such a program, which shall include disclosure of—
(i) the name and location of the program, including the names of any owners and operators;
(ii) the number and percentage of children who terminated participation prior to completion of that program in the past 5 years, including children discharged against medical advice;
(iii) any past violations of the standards required under this paragraph by the program and any penalties levied against the program as a result of such violations;
(iv) its current status (current as of the date the materials were given to the parents or guardians) with respect to State licensing requirements;
(v) the number of deaths that occurred in that program during the most recent 10-year period and the cause of each death;
(vi) the names of owners and operators of the program that have violated State licensing requirements;
(vii) information on evidence-based or promising practices employed as treatment in the covered program, and information to aid parents and

guardians in finding community-based treatment resources; and
(viii) any national, State, and local telephone hotline numbers that the program made available to children and staff members to report complaints of child abuse and neglect, or a violation of this paragraph, by the program.
(R) PROHIBITION ON DISCRIMINATION.—The entity carrying out the program shall ensure that no person shall, on the basis of actual or perceived race, color, religion, national origin, sex, gender identity, sexual orientation, or disability, be subjected to discrimination in the provision of any program or activity, in whole or in part, covered by this Act.
(S) EVIDENCE-BASED PRACTICES.—The entity carrying out the program shall ensure that the program employs safe, evidence-based practices, and that children are protected against harmful or fraudulent practices, including use of isolation or of mechanical restraints or physical restraints.