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Troubling the 'Troubled Teen Industry':
Institutional Violence, Epistemic
Injustice, and Psychiatrised Youth

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Statement of Authorship

I, Sarah Golightley, am the sole author of this thesis. The contents have not been submitted for any other degree or professional qualification. The thesis includes adapted versions of two peer-review journal articles I have authored. The journal articles were based on research undertaken for the PhD.

Signed

Sarah Golightley

30 June 2023

Research summary and abstract

In the USA, thousands of young people labelled as ‘troubled teens’ are placed in therapeutic boarding schools every year. Therapeutic boarding schools are private self-contained residential treatment programmes that operate year-round. They are part of the ‘troubled teen industry’, a multi-million-dollar network of private reform programmes for ‘at risk’ youth. Teenagers can be sent to the programmes for a range of behaviours and characteristics, ranging from substance misuse and self-harm to refusing to obey parents, to being gay or hanging out with ‘the wrong crowd’. Parents typically pay programme fees and can send their children to a therapeutic boarding school with or without the young person’s consent. Once inside the programme, young people live under a highly structured daily regimen with almost every aspect of daily life governed by a system of rules, rewards, and punishments. Students have limited, often monitored, contact with the outside world. Approaches vary, but many programmes use confrontational and shame-based interventions. To graduate and be allowed to leave the programmes, students need to meet institutional expectations and demonstrate having been sufficiently reformed. Young people may remain in therapeutic boarding schools for months or years.

Until recently, publications and research were predominantly industry-controlled success stories. A lack of government oversight left a dearth of reliable data on the industry and its long-term impacts. As a former therapeutic boarding student, I felt there was little existing research that resonated with my experience. My motivation for this doctorate was to produce work that centred on the experiences of former therapeutic boarding school students. The research critiques ways ‘deviant’ young people are pathologised and the harms that can be carried out in the name of care.

The research was conducted in multiple stages using several methods: an online questionnaire, followed by semi-structured interviews, followed by participant feedback. Former therapeutic boarding school students were eligible to participate if they were at least 18 years old and were no longer in a therapeutic boarding school. Online questionnaires gathered data on participants' backgrounds and overall therapeutic boarding school experience. Interviews sought to gain a deeper understanding of participants' experiences before, during, and after they attended the therapeutic boarding school. Case studies were created based on interview transcripts and participants were invited to provide feedback on their case studies. As survivor-led research, my lived experience was drawn on as valuable insight to be critically and reflexively engaged with rather than bias to be minimised or dismissed.

The thesis introduces concepts and literature relating to therapeutic boarding schools. An overview of the theoretical and methodological approach of the research is described. Following this is a summary report of questionnaire responses, which provide a broad overview of former ‘troubled teens’ and their experiences of therapeutic boarding schools. These experiences are described with greater depth in results chapters that focus on several specific themes: LGBTQ+ ‘conversion therapy’, seclusion and restraint, and institutional child sexual abuse. The thesis explores how former students experienced institutional violence, the ways they coped, adapted, and resisted, as well as the long-term impacts. Implications for social work, social policy, and social research are discussed and critically examined.

The thesis is underscored by a Mad Studies critique of therapeutic boarding schools as structurally violent. I discuss how young people are 'psychiatrised' by authorities who label their behaviours and feelings as signs of mental illness. Once labelled mentally ill or 'troubled', young people are seen as lacking credibility, and adults make decisions on their behalf under the auspices of protection and care. I use the term 'epistemic injustice' to describe the ways psychiatrised young people have their insights undermined by those around them. In the 'troubled teen industry', therapeutic boarding school professionals have the power to be seen as expert helpers with specialist insights into the situation of struggling youth, creating a vast power inequality between them and the 'troubled teens' who have been denied agency over their lives. These social conditions lead to violent institutional cultures.

Trigger warning

In this thesis, many forms of violence and trauma are described. I want to inform you about the topics discussed in the thesis so that you can decide how to engage with the text.

Emotional abuse, physical abuse, sexual abuse, neglect, and institutional violence are themes pervasive throughout the thesis. Specifically, there are discussions about childhood sexual abuse, institutional childhood sexual abuse, and grooming. Physical abuse is described, including acts of aggression and the use of physical and mechanical restraints. Emotional abuse appears in many forms throughout the thesis, including gaslighting, threats, 'attack therapy', 'slut shaming', anti-LGBTQ+ 'therapies', and 'brainwashing'. Other violent practices included forced detainment, seclusion, chemical restraint, sleep and food deprivation, and authorised kidnapping. There are discussions on how people have coped with trauma, including dissociation, repressed memories, and trauma bonding. There are references to suicide, self-harm, and drug and alcohol use.

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Finally, thank you to the many scholars, artists, and activists whose work has given me a roadmap for living differently.

*"They can call me crazy if I fail
All the chance that I need
Is one-in-a-million and they can call me brilliant
If I succeed"*

- Ani DiFranco, Swandive

Dedication

This PhD is dedicated to all the victims and survivors of the troubled teen industry and to finding ways to tell our stories.

I also dedicate this thesis to my grandmother, Gloria Shapiro, the first person in my family to attend university. Granny, I wish you were here to see me finish the PhD; I know you would be proud.

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Chapter one: Introduction

When I was fifteen, I was confined in a multi-billion-dollar industry most people had never heard of. A so-called ‘troubled teen’, I was stuck in a programme out of sight from the public, beyond the reach of the law, and unchecked by child protection services. The residential facility called itself a ‘therapeutic boarding school’, and it offered intensive methods to force change in young people. We were not to be ‘coddled’ with psychotherapy but ‘confronted’, made to take responsibility for all that had gone wrong in our lives. Basic living conditions were considered privileges that had to be earned, and our rights were tokens staff could take away at will. The treatment regime demanded total conformity from us. It was as if we were faulty products sent to the factory for a reset. It was extreme but justified as being in our ‘best interests’. It was a harrowing cruelty under the visage of care. Unlike most students who stayed months or years, my parents went against the school’s advice and removed me from the school after only a few weeks. As I walked out the school doors for the last time, the social worker warned me, “In three months, either you’ll be back here, or you’ll be dead.” This was my introduction to the ‘troubled teen industry’.

In the years after I got out of the therapeutic boarding school, I did not talk about it very much. The experience was incomprehensible to most of the people I knew, and in some ways, it was incomprehensible to me. At the time, it was difficult to find research on the experiences of former therapeutic boarding school students, as told by former students. Industry websites and brochures showed beautiful campuses with smiling teenagers (The CEDU School, 1988). They were full of success stories: self-destructive teens, manipulative teens, aggressive teens, drug-addicted teens, depressed and suicidal teens, sexually active teens, goth teens, video gamer teens- whatever the problem, the lives of these teens had been turned around by a therapeutic boarding school (Resolution Ranch Academy, 2020; P.U.R.E., 2023b; Help Your Teen Now, 2017). Books encouraged parents to consider therapeutic boarding schools a life-saving intervention (Case, 2008; Haid & Donnelly, 2013; Reamer & Siegel, 2009). News coverage would occasionally report abuse scandals, discussion boards would have disturbing survivor accounts, and survivor activism has always existed, but the industry was effective at minimising and dismissing these (Szalavitz, 2006; Rowe, 2004; Colloff, 2001; Atkinson, 1993; John, 2002). They were the professionals, after all.

In the US, thousands of young people labelled as ‘troubled teenagers’ are placed in therapeutic boarding schools (TBS) every year (Szalavitz, 2006; Kelner, 2023b). The residential treatment programmes claim to reform young people labelled with mental health, behavioural, and substance misuse problems. They combine education and group therapy, typically in private self-contained facilities that operate year-round. Teenagers can be sent to these schools for a variety of behaviours, ranging from rebellion and minor rule transgressions to posing a life-threatening risk of harm towards themselves or others (Mooney & Leighton, 2019). Therapeutic boarding schools are part of a broader ‘troubled teen industry’ comprised of underregulated and privatised programmes marketed as intensive treatments for struggling young people (Stockton, 2022; Chatfield et al., 2021). Due to the absence of federal regulation or oversight, there is a lack of comprehensive data about the true scale and scope of the industry (Whitehead et al., 2007; Rouse, 2022). For a multi-million-dollar industry with hundreds of programmes in operation across the country,

the lack of information available was eerily disturbing. I did not see the experiences of people like me reflected in public knowledge or professional discourse. This is the context which motivated me to work so hard for so long on a doctorate so complex; I want these former students and survivors to be heard.

Research

The research has focused on adult reflections on their youth experience inside therapeutic boarding schools (TBS). There were three successive stages of data collection: online questionnaires, in-depth interviews, and case study participant feedback. The online questionnaire was completed by over 100 people, from whom a subsample of 16 participants was interviewed, from which a subsample of nine interviews was analysed as case studies; all but one of the case study participants engaged in discussion and feedback about their case. Each research stage provided different types of insight, all of which informed the overall thesis and will be discussed in the following chapters. A large majority of participants described their overall TBS experience as 'negative' or 'very negative', and my research has largely reflected critical perspectives of the troubled teen industry. There was a wealth of important and disturbing accounts of abuse, including physical, sexual, and emotional abuse and neglect. Human rights abuses were prevalent throughout. TBS was described by many as having caused profound harm and long-lasting trauma.

The research has several aims: to centre the insights of former TBS students as experts on their own experiences, to document and analyse their accounts, to analyse the role of TBS institutional culture, and to increase awareness about abuse and human rights violations in TBS and the broader troubled teen industry. While this work has been undertaken to fulfil the requirements of a doctorate, my guiding ambition has been to produce useful and validating work for former students and survivors. I have approached the research with a Mad Studies commitment to research as a form of activism that intends to disrupt traditional power imbalances in the production of knowledge by centring the voices of service users and survivors (Faulkner, 2017; Beresford, 2020). Mad Studies critiques the social construction and regulation of people whose emotional–cognitive realities have been pathologised by the 'psy professions'—psychiatry, psychology, social work, and related 'caring' occupations (Gorman and LeFrançois, 2017; Bruce, 2021).

I began my doctorate in 2017, and most of the questionnaires and interviews were completed in 2018-2019. Unexpected world events, not least of which include a global pandemic and unforeseen challenges in my personal life, including emotional reckoning with the content of this research, have meant this thesis has taken much longer to complete than I initially anticipated. Further, the successive multi-stage data collection process required time between stages. I chose to pursue opportunities to publish open-access peer-review journal articles based on the research (Golightley, 2020, 2023). Prioritising making the research publicly available and potentially impactful was ethically important to me as an activist scholar. However, prioritising publication inevitably drew time away from writing the thesis.

The cultural landscape has changed substantially since I began my doctorate. In the autumn of 2020, celebrity entrepreneur and social influencer Paris Hilton released her documentary

This is Paris. Paris Hilton is a survivor of the troubled teen industry, including several therapeutic boarding schools, and spoke publicly for the first time about the extensive abuse she experienced inside these programmes. Her documentary has been viewed over 75 million times, bringing unprecedented media interest and public awareness to the topic of ‘troubled teens’ (Dean, 2020; Hilton, 2023). Almost overnight, my research became topical. Although troubled teen industry survivor activists have been speaking up for decades, this brought an unprecedented amount of attention to the topic. Survivors' stories can now be accessed much more readily than when I started, and there are now too many accounts for the industry to dismiss them all as the conjecture of ‘crazy’ and manipulative ex-students. This thesis is coming into form in a critical moment of ‘troubled teen industry’ survivor activism.

Thesis structure

In the next section, chapter two, a literature overview introduces readers to therapeutic boarding schools and the concept of ‘troubled teens’. This chapter summarises the contextual details necessary for understanding my research. In chapter three, I describe the study’s theoretical approach and the principles behind Mad Studies and survivor-led research. Chapter four is about the research aims and methods. I detail my use of questionnaires, interviews, and case studies, alongside the strengths and limitations of this approach. In the first of the results chapters, chapter five, I report on the questionnaire responses. The chapter describes participants' demographic backgrounds and themed responses to questions about their therapeutic boarding school experience. Chapter six draws on three case studies to theorise how sanism, adultism, and epistemic injustice operate in therapeutic boarding schools. The remainder of the results chapters focus on specific forms of institutional violence: LGBTQ+ ‘conversion therapy’, seclusion and restraint, and institutional child sexual abuse. Finally, in chapter ten I conclude with a discussion of the implications for social policy, practice, and research and critical discussion and reflection on the research process. Participant quotes are integrated into the chapter to include their perspectives on future policy and practice and to provide descriptive examples of the complex realities of conducting this research. I describe a need for deeper cultural change that responds to the needs and struggles of youth in more empowering and caring ways.

Chapter two: A troubling industry

This chapter provides an overview of key concepts and context necessary for the reader to understand this research. The material discussed includes peer-review publications, news articles, memoirs and parent self-help books, government reports, legislative acts, company reports and websites, survivor-advocate websites, as well as documentaries and public survivor accounts. The intention is to provide sufficient foundational material about the industry overall to enable the reader to locate this research within a broader context. In addition to the overview provided in this chapter, at the beginning of each substantive chapter, I have provided a focused literature review specifically on the topic theme.

Overview of the industry

57,000 to 300,000 young people are estimated to be in the troubled teen industry annually, generating millions in yearly profits (Chatfield, 2019, p. 44; Krebs, 2021; Breaking Code Silence, 2022). The wide variation in estimates is due mainly to definitional and measurement discrepancies, and it is worth noting that they include a range of youth residential programmes and not therapeutic boarding schools specifically. Hundreds of therapeutic boarding schools are currently in operation (National Association Therapeutic Schools and Programs (NATSAP), 2019; Teen Challenge Schools, 2023; Unsilenced, 2023b). However, the exact number of schools and pupils is unknown due to the lack of regulatory oversight (Whitehead et al., 2007; Robert, 2021). No official data records what is happening in the industry (US Government Accountability Office, 2008). With these limitations, it is unclear what the outcomes are for former therapeutic boarding school students (Friedman et al., 2006; Mooney, 2020). Furthermore, it is unclear to what extent the type of students admitted and the type of treatment these students receive may have changed over time.

Young people can be placed in TBS through various means, and admissions can occur with or without consent. While some young people agree to attend programmes, others are deceived, coerced, or forcibly taken by ‘transporters’ (Dobud, 2022; Robbins, 2014). Parents can hire ‘transporters’, known colloquially as ‘goons’, who will usually come to an unsuspecting young person’s home in the middle of the night, wake the teenager and tell them they can come “the easy way or the hard way”, to be obedient or to be physically overpowered and taken by force (Stein, 2019; Solomon, 2016; Ingram, 2023; Miller, 2022a). They may be taken directly to a TBS or arrive first at wilderness therapy, an intensive outdoor residential treatment where teens are cut off from the outside world, hike almost all day, live in makeshift, roving camps, and participate in group therapy (Magnuson et al., 2022; Okoren, 2022; Trails Carolina, 2022). These troubled teen programmes may be recommended by ‘educational consultants’, an unregulated advisory role with financial ties to the industry (Hale, 2012; P.U.R.E., 2023a). Other parents may come across the programmes through internet searches or word of mouth.

The admissions process may not require independent assessment or formal diagnosis (Behar et al., 2008). The annual fees for therapeutic boarding schools can be upwards of USD \$ 100,000 (Kaplan et al., 2023; Larson, 2023b; The Envoy Group, 2019). Many therapeutic boarding schools cater to wealthy families with power and privilege (Pfaffendorf, 2017; Francis, 2012). However, some schools advertise themselves as

affordable, faith-based therapeutic boarding schools, although their total costs are rarely advertised; so how 'affordable' these schools are is unclear (Elk Mountain Girls Academy, 2023; Help Your Teen Now, 2019). It is uncommon, but some students receive bursaries, occasionally fees are covered by health insurance, and there is the potential for state funding under provisions for students with special educational needs (NATSAP, 2023b; U.S. Department of Education, 2022). Additionally, there are increasing reports of state social services, including foster care and juvenile justice systems, procuring placements for teenagers in private TBS (Muzquiz, 2021; Krebs, 2021; Somers et al., 2021).

Once inside a programme, it is often difficult for students to leave without permission from their parents and staff, although there are many reports of students who have run away (Bloch, 2020; Murdock, 2016). Campuses are typically in rural locations, and communication with the outside world is restricted and monitored (Szalavitz, 2006; Chatfield et al., 2021). Students typically eat, sleep, study, work, and engage in 'therapy' or group work on campus and have few opportunities to leave the TBS grounds. The schools operate a highly structured schedule with a strict regimen; nearly all aspects of daily life are governed by a system of rules, rewards, and punishments. In most circumstances, teenagers do not have the right to refuse treatment (Forstner, 2022; Wipond, 2023). For many, students can leave only by completing the programme, abiding by the rules, and demonstrating (or mimicking) personal transformation.

There is a lack of accountability for therapeutic boarding schools where poor living conditions and harmful therapeutic practices have been reported (National Disability Rights Network, 2021). Psychological, physical, and sexual abuse and neglect have been reported as widespread and systemic (CCHR International, 2023; Stockton, 2022; Beattie, 2020; VICE News, 2021). There are also reports of forced labour; TBS students made to do long and arduous hours of grounds maintenance and farm work, domestic work, and sometimes arbitrary manual labour with the sole aim of physical exhaustion, such as moving heavy objects from one place to another and back again (Department of Homeland Security, 2023; Stop Institutional Child Abuse, 2023). TBS treatment has often been referred to as "controversial treatment," "behaviour modification," "tough love", and "confrontation therapy," but many former students/survivors have referred to it as "brainwashing" and "attack therapy" (Fleck, 2021; John, 2002; Associated Press, 2016; Szalavitz, 2007; Aitkenhead, 2003; Cooper, 2021). Therapeutic boarding schools have been shut down on rare occasions, but many remain open despite consistent abuse allegations and lawsuits (Miller & Gilbert, 2022b; Madarang, 2023). Some avoid negative publicity by closing and reopening under a new name (Colloff, 2001; Barnas, 2023; Bellow, 2021). Activists have been working to raise public awareness of abuse and human rights violations and to shut down programmes (Scheff, 2008-2010; Cole & Mellinger, 2022; Unsilenced, 2023a).

The 'problem child'

The 'troubled teen' is a nebulous concept with no clear agreed-upon standards for who is and is not designated 'troubled'. The range of behaviours, attitudes, and emotions industry professionals can label as 'out of control' or 'risky' is limitless (Szalavitz, 2006; Mooney & Leighton, 2019). Parent testimonies vary from believing their child was struggling with trauma, eating disorders, depression, and drug addiction, to others whose teenagers were reportedly disrespectful and defiant; "Our Son Was Out of Control – He Did What He

Wanted!” (Empower My Teen, 2023; Clearview Girls Academy, 2023; Ingram, 2023). A breach of moral and religious ideals could be framed as self-destruction in youth; one website has a page offering advice to parents on “De-weaponizing your daughter’s sexuality” (Help Your Teen Now, 2017). The Eagle Ranch Academy reaches out to parents,

“Is Your Son or Daughter Struggling? Eagle Ranch Academy the #1 Rated Therapeutic Boarding School. ERA help teens overcome abuse, depression, anxiety, phone addiction, behavior health, and lack of respect for authority” (Eagle Ranch Academy, 2023).

Educational consultants and TBS websites offer ‘troubled teen’ checklists and self-assessment quizzes (Turning Winds, 2023; Best Therapeutic Boarding Schools, 2019). There are therapeutic boarding schools which are more clinical and require a mental health diagnosis; one broadly states they enrol teens “across the diagnostic spectrum” (Grove School, 2023b). While most have teenagers as their target demographic, some TBS admit children as young as ten years old (Asheville Academy, 2023).

Throughout the decades, the troubled teen industry has depicted youth as in crisis, citing rises in teenage violence, mental health problems and drug addictions, as well as moral decline and sexualisation (Scheff, 2022; Hess et al., 2012; Currie, 2006). The industry has capitalised on parents’ fears, anxieties, and sense of exhaustion (Rouse, 2022). Youth deviance has been constructed as dangerous and in need of adult intervention (Marcus, 2002). From the perspective of former ‘troubled teens’, however, some describe life-threatening self-destructive behaviours, such as repeat suicide attempts, while others describe more general teenage rebellion and tension with parents (Beattie, 2020; Stockton, 2022). Hilton remembered the students at a TBS she attended,

“Most of those kids were like me: disobedient ravers from conservative families and ADHD kids who got kicked out of school. Some had experimented with weed or molly, but none of us were as street smart as we thought we were. A lot of kids were gay—or gay-ish—which upset their religious parents. Foster-system floaters came from bad situations that had nothing to do with them, but they had to be parked somewhere that looked okay on paper. Other kids lived in darker worlds: addiction, violent predatory behavior, and suicidal depression” (Hilton, 2023, p. 93).

The ‘troubled teen’ could be understood as any number of things, including just ‘teen’; all youth have could potentially fall under the label. While many have serious psychological struggles, the label has situated ‘the problem’ as internal to the individual, often failing to address problems in the family, local community, or broader cultural and systematic factors.

White, wealthy, and ‘troubled’?

In the news and popular culture, the ‘troubled teen industry’ has been portrayed as “brat camps”, “luxury prisons”, and “elite” boarding schools (Shaprio, 2005; Shaw & Hagen, 2023; Fleck, 2021; Brown, 2002). In a recent interview with *Vogue*, the author of a new book about therapeutic boarding schools described the programmes as exclusive to the “1 percent of 1 percent that can afford this” (Samantha Leach in Alder, 2023). The widespread

media coverage of Paris Hilton is emblematic of this depiction (Hilton, 2023). Hilton and other survivors have sometimes appealed to their ‘innocence’ to accentuate the tragedy of their experience; an often used refrain is, “I was treated like a criminal” (Kelner, 2023a; Stockton, 2022). Their experiences in the ‘troubled teen industry’ have been likened to and contrasted with the forced confinement of criminalised youth in the USA, mainly low-income and racialised youth who are imprisoned (Meiners, 2017; Aviv, 2021; Rood, 2016; Williams, 2013). The consequences of the media’s ‘privileged youth’ representation are a confused and sometimes contradictory portrayal, the elite ‘troubled teen’ as a lesser victim, spoiled and in need of ‘toughening up’, and as a greater victim, shocking to the public who expect white and wealthy people to be treated more humanely.

The lack of definitional consensus and publicly available data make sweeping claims about class and race difficult to substantiate. While upper-class and white ‘troubled’ youth attend therapeutic boarding schools in high numbers, the broader demographic spread of therapeutic boarding school students is largely unknown (Pfaffendorf, 2017). I argue there are three main reasons we may see such stark racialised disparities in the ‘troubled teen industry’. Black/African American young people are more likely to have their childhood and youth deviance criminalised and go to prison instead of residential treatment (Edwards & Madubonwu, 2020; Reiman & Leighton, 2020). Private parent-pay programmes typically charge extraordinarily high fees, which are less affordable to many racialised minorities, especially for low-income Black/African American families (Mooney & Leighton, 2019). Lastly, there is a terminological and representational bias, or whitewashing, in how the ‘troubled teen industry’ is defined and portrayed, and this may have caused researchers and journalists to overlook a wider array of youth intervention programmes. This last point is especially poignant as many recent deaths in treatment have been Black/African American and Native American teenagers (Aviv, 2021; Kelner, 2023b; Bey & Cohen, 2020; Diamond Ranch Academy, 2017). While these deaths have been reported, it is hard to find any media coverage which includes the perspectives of Black ‘troubled teens’.

Peer-review literature

The academic peer-review literature on therapeutic boarding schools is notably small. Although the volume of literature on the troubled teen industry has increased exponentially in recent years, the vast majority has been in the press and popular culture. Following the interest in Paris Hilton’s story, coverage of the troubled teen industry is now a constant in the news, on podcasts, and newly published books (Rosen, 2021; Gilpin, 2021; Hilton, 2023; Maldonado & Simmons, 2023; Cole & Mellinger, 2022; Bloch, 2020; Kilander, 2021; Leach, 2023). Any systematic, comprehensive review of all these materials would be a near-impossible task and quickly become outdated. Instead of attempting to synthesise all the information now available, I have chosen to conduct a focused review of peer-review journal articles on therapeutic boarding schools (Ridley, 2012). The review summarises the extent of available peer-review literature and the contrasting methods and findings of authors.

I performed a scoping review in June 2023 on EBSCOhost Complete (Munn et al., 2018; Mak & Thomas, 2022). I searched for publications that contained any of the following key

phrases in the title or abstract: “therapeutic boarding school*”, “therapeutic residential school*”, and “emotional growth boarding school*”. EBSCO returned 127 results. There were only 30 results when this was limited to peer-reviewed articles (after eliminating duplicates). I reviewed the title, abstracts, and journal names and removed articles that were about schools based outside of the USA, focused on topics not relevant to TBS (i.e. therapeutic work in standard boarding schools), and publications which had been misclassified as peer-review (i.e., digital newsletters). This reduced the number of articles to 14. I returned to the database and applied the same rules to the search term “troubled teen industry”, which returned three additional papers. I compared this with my personal reference library and added the following search terms: “residential treatment center school”, which had one additional article, “alternative residential school” yielded another; and “therapeutic high school” + “boarding”, which returned four articles written by a TBS principal. I included several papers that focused on wilderness therapy/outdoor behavioural health, but which mentioned therapeutic boarding schools in the abstract. There was no date range specified in the search, but the oldest publication was from 1986, and around half of the articles have been published since 2017, the year I started my PhD.

When I searched EBSCOHost, one of the largest academic databases in the world, using the most common phrases relating to therapeutic boarding schools, I could find only 23 peer-review articles, two of which were my own¹. The articles produce a mix of perspectives and use a variety of methodologies. Several articles were not captured in the EbscoHost search, and I have added this to the summary of peer-review literature. The publications can be broadly categorised into those written by TBS staff, external researchers, and by or with TBS survivors.

The author with by far the most publications on therapeutic boarding schools is Thomas E. Bratter, former president of the John Dewey Academy (Bratter, 1975; Bratter, 1981; Thomas E Bratter, 2007; Bratter & Sinsheimer, 2008; Bratter, 2011). Bratter wrote extensively about his ‘unconventional’ therapeutic work, or as he described it in the title of a 2008 paper, “Waging War with a Gifted, Manipulative, and Self-Mutilating Adolescent” (Bratter, 2008, p. 51). He was an advocate of “compassionate confrontation psychotherapy,” a form of so-called “reality therapy” (Bratter, 2011). He considered the approach highly effective, despite outside criticism,

“Confrontation is the primary psychotherapeutic tool which pierces attempts at self-deception and avoidance of reality. There are two phases of confrontation, i.e., the painful unlearning process and the supportive relearning process. ...critics do not understand” (Bratter et al., 1986, p. 55)

Bratter’s publications were based on professional self-reflection, anecdotes, and case studies. Aside from Bratter, other professionals have published self-reflection pieces, as can also be seen in Slife, who reflects favourably on the “virtues and ethics” of the Greenbrier Academy (Slife, 2012, p. 35; Baber & Rainer, 2010).

¹ I have not included work published in the *Journal of Therapeutic Schools and Programs*, as this journal is self-published by the industry and is not recognised in research databases as peer-review.

In the mid-to-late 2000s, a series of articles critiqued the human rights records of therapeutic boarding schools and the troubled teen industry more broadly. Survivors, academics, journalists, and other advocates formed the Community Alliance for the Ethical Treatment of Youth (CAFETY) and the Alliance for the Safe, Therapeutic and Appropriate use of Residential Treatment (ASTART). In an article, ASTART exposed industry abuse and mistreatment, including “harsh discipline, inappropriate seclusion and restraint, substandard psychotherapeutic interventions, medical and nutritional neglect, rights violations and death” (Friedman et al., 2006, p. 295). An article authored by CAFETY writes,

“The very youth, who are in most dire need of empathy, care, and holistic treatments, are being bombarded by trauma-inducing interventions within the walls of facilities, masquerading as optimal models of healing and hope” (Whitehead et al., 2007, p. 348).

Their criticisms included the problems of unlicensed facilities, lack of monitoring or oversight, lack of evidence-based treatment modalities, and the widespread abuse of teens who cannot legally refuse treatment (Mohr et al., 2010; Mohr et al., 2009; Behar et al., 2008; Behar et al., 2007). This work coincided with the US Government Accountability Office reports on deaths in treatment programmes, reports of abuse, deceptive marketing techniques, and the need to address the lack of federal regulation and oversight (GAO, 2007, 2008c, 2008a, 2008b).

There are a small but increasing number of research studies on TBS. Research methods have included self-report questionnaires, interviews, and ethnographies. Ethnographic accounts by external researchers have had mixed conclusions, offering critiques and describing TTI successes (Marcus, 2002; Pfaffendorf, 2017). Of the research which has generally been supportive of TBS, they have often relied on parent-reported outcomes, sometimes in conjunction with the perspectives of current students (Bolt, 2016; Hess et al., 2012). This is a poor measurement tool considering students' communication with parents is monitored while they are in treatment, and research on current students is complicated by students who may not feel safe to report honestly, especially if staff are part of the research process. Further, as is discussed in the retrospective studies discussed next, it may take many students and families years to process complex and sometimes traumatising institutional experiences.

Relatively recently, and coinciding with my research, two other survivor-researchers have conducted questionnaires and interviews on retrospective accounts of former ‘troubled teens’ (Chatfield et al., 2021; Mooney & Leighton, 2019). Marcus Chatfield’s work has conceptualised TTI programmes as “totalistic teen treatment,” with high-control environments thought-reform techniques, while Heather Mooney approaches the research through a critical criminology perspective (Chatfield, 2019, p. 133; Mooney, 2022). Like my research, participant recruitment was based on convenience sampling techniques. The retrospective accounts of former ‘troubled teens’ show much higher rates of negative experiences than studies looking at short-term outcomes reported by current students. Mooney’s study of one therapeutic boarding school found that the overall effectiveness was divided,

“Those who had spent time at YAS (Youth Academy Services) could be divided into thirds based on their opinion about the program: one-third felt that it helped them; another third stated it did not really change much; and the last third felt they got worse” (Mooney & Leighton, 2019, p. 621).

Marcus Chatfield surveyed over 200 former ‘troubled teens’, most of whom reported negative experiences; his research indicates that “the strongest predictor of low-quality treatment experience is the totalistic nature of the milieu” (Chatfield et al., 2021, p. 139; Chatfield, 2018). In other words, the more controlling the institution was, the worse the outcomes were for students. Over the last few years, work by troubled teen industry survivor scholars appears to have gained momentum (Rouse, 2022; Mater, 2022).

Rights and the law

The troubled teen industry's law and social policy context is multi-layered, evolving, and variable across states. The TTI has been able to prosper for decades with minimal government oversight, partly because the US, in effect, affords parents' and private businesses' rights primacy over the rights of children (Forstner, 2022). Parents' rights supersede their children's rights, and parents have a right to raise their children with minimal government interference (Aviv, 2021; Whitehead et al., 2007). Therefore, parents can send their child to treatment without the child's consent and without the advice or assessment of a licensed healthcare professional (Mohr, 2009). Further, the rights of parents can be signed over to staff and facilities, which can operate ‘in loco parentis’ (Latin for “in place of the parent”) (Robbins, 2014). Young people do not have the right to refuse programme admission, nor can they freely leave as minors.

The US operates from a general free-market mentality that allows private businesses to operate with minimal interference from the state (Gaffney, 2015). Furthermore, the separation of church and state means therapeutic boarding schools registered as religious institutions have additional protection from government intervention (Szalavitz, 2001). There is a variability of regulations and programme definitions across states, leading to inconsistencies in the protection of youth in residential care (Friedman et al., 2006; US GAO, 2022). Depending on how a programme is registered and in which state it is based, a therapeutic boarding school may not be required to be licensed, accredited, or inspected (Evans, 2022; Iryes et al., 2006). All laws exist within parameters, and states can intervene in cases of child abuse, but the odds are stacked against children, and the US repeatedly fails to protect the welfare of ‘troubled teens’.

International law

The USA is the only member of the United Nations to have never ratified the UN Convention on the Rights of the Child (UNCRC, 1989). US Republican politicians saw the UNCRC as a potential threat to the country's sovereignty, “arguing that it conflicted with U.S. laws regarding privacy and family rights” (Congressional Research Service, 2015, p. 1). The US is also one of a handful of countries that never ratified the UN Convention on the Rights of Persons with Disabilities (UNCRPD, 2006). While the USA has made symbolic commitments to the principles of these conventions, there is no duty for the US government to uphold these commitments (Mehta, 2015). Conventions ratified by the USA include the Convention

Against Torture (UNCAT, 1984). The US is also a signatory of the Universal Declaration of Human Rights (UDHR, 1949). Protection from “cruel, inhuman or degrading treatment or punishment” is a key principle of universal human rights (UDHR, 1949, p. Article 5). Under international law, the US is obliged to prevent and investigate torture acts, prosecute perpetrators, and provide redress to victims/survivors (Convention against Torture Initiative, 2023). While there is potential for UN Rapporteurs to apply pressure on the US government for failing to protect children in the troubled teen industry, such a measure has not occurred.

Federal law

No federal laws specifically address therapeutic boarding schools, the troubled teen industry, or similar residential youth treatment programmes (Federal Trade Commission, 2008; Forstner, 2022). However, there are multiple relevant federal laws, including the Child Abuse Prevention and Treatment Act (CAPTA, 1974, 2010), the Individuals with Disabilities Education Act (IDEA, 2004), and the Civil Rights of Institutionalized Persons Act (CRIPA, 1980). Respectively, these legally enshrine the government’s duty to identify and protect children from abuse and neglect, provide educational access that meets the individual needs of disabled children, and uphold the human rights of institutionalised persons. However, these fail to protect youth in the ‘troubled teen industry’, as privately operating facilities are exempt from CRIPA, and IDEA has facilitated funding for children to attend TTI facilities (US Department of State, 2019). Efforts to introduce federal regulation have so far been unsuccessful. Notably, the 2008 Stop Child Abuse in Residential Programmes for Teens Act would have prohibited youth residential facilities from using disciplinary techniques, including seclusion and restraint, withholding of essentials such as food or shelter, and psychological abuse “designed to humiliate or degrade a child or undermine a child’s self-respect” (S. 3031 — 114th Congress, 2016, p. 5; H.R. 5876 — 110th Congress, 2008).

TTI survivor advocacy groups have successfully lobbied for the introduction of the bipartisan bill Stop Institutional Child Abuse Act (SICAA) (S.1351- 118th Congress, 2023), which would establish a ‘federal work group on youth residential programmes’ and a national review of youth treatment facilities. The Bill, introduced in both the Senate and House of Representatives, aims “to improve the dissemination and implementation of best practices regarding the health and safety (including with respect to the use of seclusion and restraints), care, treatment, and appropriate placement of youth in youth residential programs.” Enhancing oversight, advocates say, would increase transparency, “By enacting SICAA, we can help prevent the abuse and neglect of youth in residential programs or facilities across the United States through transparency and eventually reduce the usage of institutional settings overall to prioritize community-based and family-centered care” (Stop Institutional Child Abuse, 2023). The bill would enhance national data collection but does not criminalise harmful institutional practices. It has received support from many survivor-activists, including Paris Hilton, as well as from the troubled teen industry itself, with NATSAP stating they “applaud” the legislative efforts (NATSAP, 2023c; Associated Press, 2023).

State law

State governments hold the most influence on day-to-day troubled teen industry operations, resulting in significant differences in law and policy across states (U.S.

Government Accountability Office, 2022, 2008b). Privately operated therapeutic boarding schools may or may not be required to have qualified health professionals and teachers, have independent inspections, or report the use of seclusion and restraint (Iryes et al., 2006; National Disability Rights Network, 2021). States like Florida have allowed Christian therapeutic boarding schools to be exempt from state regulation as faith-based organisations (Zayas, 2012; Aviv, 2021). Some TBS operate with no licensure or have been allowed to operate as licensed facilities despite significant violations of state law (Friday, 2017; Friedman et al., 2006).

Over the last five years, there has been an increase in state reforms regarding youth residential treatment facilities, in part due to increased lobbying from Paris Hilton and advocacy groups like Unsilenced (Hilton, 2021; Reinstein, 2021). This year Montana passed reforms (HB 218) that include unannounced state inspections of youth residential facilities (Larson, 2023a). Last year, Oregon enacted legislation that requires all 'secure youth transportation services' to be licensed by the state and meet a set of minimal requirements (Oregon Department of Human Services, 2022). Oregon State Senator Sara Gelser explained:

“We passed legislation last year, the first state in the nation to do this, telling those companies that prior to providing that type of transport service when a trip began or ended in Oregon, they needed to be licensed as a childcare agency. Because nobody was checking to make sure they’ve done background checks. There were no checks or balances on the physical restraints, parents actually signed contracts that gave them permission to physically manhandle the kids ” (Kunkler, 2022).

The 2022 law (SB 710) also required that therapeutic boarding schools employ qualified teachers and that staff receive ongoing training (Oregon Secretary of State, 2022). These cover some of the basics, but there remains no requirement for licensed social workers, counselling psychologists, psychiatrists, or mental health nurses to be on staff.

The state with the most significant number of troubled teen facilities, Utah, passed new legislation in 2021 (SB 127). The legislation required increased state inspections of TTI facilities and for programme staff to report 'critical incidents' and use seclusion and restraints (Utah Office of Administrative Rules, 2022; Miller & Gilbert, 2022a). “Utah's law, signed by Gov. Spencer Cox in March, prohibits a congregate care program from using ‘a cruel, severe, unusual or unnecessary practice on a child,’ which includes repeated physical exercises and withholding personal interaction” (Robert, 2021). This is not Utah’s first law addressing the TTI; a 2005 bill required facilities to be licensed by the state and prohibited solitary confinement (Utah State Legislature, 2005). However, the law was generally ineffective, “regulations are not worth the paper they are written on if they aren't enforced, and Utah doesn’t seem to enforce these regulations well at all” (Szalavitz in Higginbottom, 2015). In the ten years following the 2005 legislation, six “avoidable” deaths were recorded (Higginbottom, 2015). There is a risk that history may repeat itself; three young people have died in Utah programmes in less than two years since the latest legislation was enacted (Kelner, 2023b). State Senator Mike McKell, one of the bill’s co-sponsors, reflected, “I think we need to enhance the tools... Straight up, I think our tools are not strong enough today” (Miller & Craft, 2022).

Industry self-regulation

While many states do not require accreditation or membership of industry associations, over the decades, these have emerged and gathered momentum. The largest industry membership organisations are the National Association of Therapeutic Schools and Programs (NATSAP) and the Outdoor Behavioural Health Council (OBHC), with the latter focusing primarily on wilderness therapy programmes. NATSAP was founded in 1999, initially with 43 programmes as members (Friedman et al., 2006). Currently, 25 ‘therapeutic boarding schools’ and 76 ‘residential treatment centers’ are listed in their membership directory (NATSAP, 2019). NATSAP’s website describes the association “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” (NATSAP, 2023d). OBHC state on its homepage, “The OBH Council sets the standard that families can trust” (Outdoor Behavioral Healthcare Council, 2023b). In this lacunae, NATSAP and OBHC have positioned themselves as industry leaders in quality care; to directly quote the NATSAP motto, “Guiding the way” (NATSAP, 2023a).

Many therapeutic boarding schools and TTI websites will proudly display the NATSAP or OBHC logo. The language of websites can be ambiguous, and parents may mistake membership of an industry lobbying organisation for independent accreditation and quality assurance (U.S. Government Accountability Office, 2008c). More recently NATSAP and OBHC have begun to require members to attain “independent accreditation” (Outdoor Behavioral Healthcare Council, 2023a; NATSAP, 2023a). The NATSAP website explains its top reason for the introduction of an accreditation requirement:

“It would improve safety and treatment effectiveness for programs. This would give our association more credibility in the eyes of those who want to shut us down, legislate, or over-regulate us. This would give us a stronger voice, one that could be heard with more authority and influence on Capitol Hill” (NATSAP, 2023a).

The requirement for accreditation is part of their lobbying effort and maintaining clout as an industry. However, the accreditation bodies are questionable, particularly in light of the claim of independence. An accrediting body recognised by NATSAP and OBHC is the Association for Experiential Education (AEE), whose accreditation council includes people who currently or previously have worked in the industry (Association for Experiential Education, 2023). Like NATSAP’s insular “peer review” industry-run journal, the accreditors have links to and sometimes are part of this lucrative industry (NATSAP, 2017). It is not clear who, if anyone, regulates the accreditors.

Industry self-regulation allows for programmes to posture as virtuous institutions of esteemed quality and to do so without basic quality standards and safety measures having to be implemented. For example, in Massachusetts, one NATSAP member and New England Association of Schools and Colleges (NEASC) accredited therapeutic boarding school, the John Dewey Academy (JDA), operated for over a decade by a principal who had been formally charged with illegal restraint, sexual assault, and rape of an underage female student (The Berkshire Eagle, 1993; Hartford Courant, 1995). He pleaded no contestation, but this appeared to have no impact on the school’s membership or accreditation status. Astoundingly, the school *gained* accreditation while he was on trial. As quoted by a local

paper at the time, the school principal Thomas E. Bratter was complimentary of NEASC's accreditation decision, "The New England Association of Schools and Colleges has demonstrated its integrity because, in view of my legal difficulties, the decision could have been delayed" (The Berkshire Eagle, 1993).

In Massachusetts, staff at private schools are not required to undergo criminal record checks (Unsilenced, 2022). Bratter lost his license as a therapist but not his status running a speciality residential facility for vulnerable youth (Division of Professional Licensure, 2007; Behar et al., 2007). Bratter has written, boasted even, of the shockingly lax Massachusetts state requirements:

"In the Commonwealth of Massachusetts, there are no regulations other than local building, health and zoning which govern proprietary residential essentially educational programs if no state or federal funds are used. The John Dewey Academy could exist without any accountability to any agency. It was my decision to seek state and national accreditation neither of which impact on my style of leadership" (Bratter, 1991, pp. 62-63).

As Bratter plainly states, accreditation had no impact on his "style of leadership". Student accounts describe pervasive abuse, including sexual abuse, perpetrated by Bratter and colleagues over multiple decades (Fleck, 2021; Maldonado & Simmons, 2023). He continued to run the school until he died (Chartock, 2021). The school maintained its memberships and accreditation but eventually closed due to financial difficulties in 2020 – it has claimed plans to reopen at a later point (Bellow, 2021).

Reliance on private accrediting associations is misplaced, as they can have inconsistent standards, lack transparency, and lean towards "institutional purposes, rather than public purposes" (Dickeson, 2006, p. 3). Industry self-regulation is problematic precisely because it is industry-led. With the increased news coverage of abuse in TBS, NATSAP has been remarkably effective in advocating on behalf of its membership; their public relations tactics deride abuse while suggesting themselves as the solution to assuring teens' safety (Ingram, 2023). A new website, listed with the NATSAP and OBHC logos, called Other Parents Like Me provides inspirational narratives and support for parents struggling to control their teenage children (Other Parents Like Me, 2023). These industry associations have adapted to the heightened negative publicity that has been present since Paris Hilton's documentary. The market does not regulate itself, and the lack of publicly available data allows for institutions to dominate discourse about the effectiveness of their programmes (Friedman et al., 2006).

A globalised industry

The USA's penchant for private healthcare and minimal private sector regulation has made it uniquely fertile ground for the TTI. However, some TTI programs are designed for American families but have campuses outside of the United States (Unsilenced, 2023b). Their international locations further complicate the law and policy context of these. Some of the most infamous American therapeutic boarding schools have been in Latin America. For example, the Utah headquartered World Wide Association of Specialty Programs and Schools (WWASP) was one of the largest TTI operators in the early 2000s and had therapeutic boarding schools in Samoa, Mexico, Jamaica, Costa Rica, and, briefly, also in the Czech Republic (Weiner, 2003; Lebor, 1998). LGBTQ+ American teenagers were sent for

'conversion therapy' at Escuela Caribe/Caribe Vista School in the Dominican Republic (Sugiuchi, 2016; Logan, 2014). These programmes have closed following extensive abuse allegations, lawsuits, and arrests (Aitkenhead, 2003; Rowe, 2004; Szalavitz, 2007). A currently operational TBS in Costa Rica markets its international location as beneficial for American students; the foreign, unfamiliar environment offers a supposedly "therapeutic disorientation" (New Summit Academy, 2023). The number of US programmes with school campuses abroad appears to have waned over the last decade, but the actual number is difficult to gauge.

Many therapeutic boarding schools and TTI programmes will state that they accept students from across the world (Diamond Ranch Academy, 2023). Like parents in the USA, some come across the programmes via online search engines or word of mouth. Educational consultants, based in the USA or outside of the USA, are also on hand to advise families on which facility they should send their child to (Off The Rails Kids, 2020). For example, an educational consultant in Toronto reportedly placed 3 to 10 Canadian teens in the TTI annually for over thirty years (Beattie, 2020). Like with American families, the young person may or may not arrive willingly, and they can be subject to authorised kidnappings. One 'transporter' reported in 2014 that he would charge £3500 to take a child from the UK to a US programme; he transported over 2000 teenagers from within the USA as well as Canada, Mexico, Dubai, Iran, Israel, Brazil, Hong Kong, Greece, Australia, and Britain (BBC News, 2014; Curry, 2009). The legality of forcible transportation in these respective countries is unclear. There is a gap in regulation and protection for children from abroad sent to USA programmes, underlined by a lack of awareness.

Historical emergence

To understand how therapeutic boarding schools operate today, it is important to understand their historical context. Many narrativise the troubled teen industry's history beginning with the therapeutic boarding school CEDU in the 1960s (Szalavitz, 2007; Shea, 2017; Hilton, 2023). However, this has curiously overlooked several programmes that opened before CEDU. Depending on how therapeutic boarding schools are defined, these can be traced back to the late 1800s. I have chosen to include three strands of the early development of therapeutic boarding schools: residential schools for cognitively and emotionally disabled children, residential Christian reform schools, and the emergence of the troubled teen therapeutic community.

Boarding schools for children with emotional and cognitive disabilities

The earliest traces of therapeutic boarding schools in the USA are those that did not distinguish between cognitive and emotional disability. They were established as progressive institutions to educate disabled, or 'defective', children (Devereux, 1909). In 1883, Margaret Bancroft opened the Haddonfield School for the Mentally Deficient and Peculiarly Backward (Bancroft & Farrington, 1909). Her widely-praised work focused on creating from the 'feeble-minded' well-tempered citizens (Keen, 1893). In 1915 Chicago, a residential school for 'emotionally disturbed' children, was opened in collaboration with the Rush Medical College and the University of Chicago (Epstein, 2005). Initially a clinic to assess children of "doubtful mentality", it transformed into a speciality boarding school called the Orthogenic School (O-School, 2023, p. 1). Several years later, Helena T. Devereux opened a

boarding school which specialised in treating children with what would today be referred to as cognitive, psychological, and developmental disabilities; she described her work in the “foreign slum district” of Philadelphia, “These children were reported not only as being stupid, but ‘queer’. It is hard to define what is meant by the term but it did mean that the child to whom this applied was singled out from other children” (Devereux, 1909, p. 45). Iterations of these programmes remain open today (Bancroft School, 2023; O-School, 2023; Devereux Advanced Behavioral Health, 2023).

To my knowledge, the Grove School in Madison, Connecticut, founded in 1934, is the oldest example of a continuously operating programme that self-describes as a therapeutic boarding school. Their website states, “We are one of the oldest, private, independent programs of its kind in the United States. Founded in 1934 and originally called a Residential Treatment Center, Grove is now officially a Residential Education Center, more affectionately known as a Therapeutic Boarding School” (Grove School, 2023a). A 1937 advertisement for the school states its purpose as “for character development – all types of behavior difficulties- complete schooling from nursery through high school- beautiful home atmosphere – a progressive country boarding school” (Perlman, 1937). The programme's roots are in Jewish social work and family welfare:

“The owner of The Grove School was Jess Perlman, a social worker previously employed by Jewish Family Services. In 1934 he had come to Madison and purchased a 90-acre state game farm with some small buildings on it, and started a small school for troubled young children. Over the years the concept for a vital residential treatment center grew and was very exciting to see” (Davis, 2014, p. 12).

The facility would remain relatively small under Perlman’s leadership; in 1956, there were only 16 students (Caulfield, 2020). Over the decades, with new owners, Grove became a private for-profit facility with over 100 students today (Davis, 2014; Grove School, 2023b).

Christian reform schools

In 1958 Assemblies of God pastor David Wilkerson founded the world’s largest network of drug and alcohol programmes: Teen Challenge (Teen Challenge, 2023). Pastor Wilkerson believed “medicine does not have an answer for drug addiction”; instead, he argued recovery should be rooted in spiritual awakening and “personal culpability” (Dufton, 2012). Teen Challenge began in New York as a gospel-driven drug rehabilitation community for gang members and other ‘troubled teens’ (Global Teen Challenge, 2020). The goal was to achieve drug abstinence and Christian observance. Reportedly, over the decades, Teen Challenge’s prayer-as-therapy approach has involved LGBTQ+ ‘conversion therapy’ and the conversion of Jewish people to followers of Jesus (Goodstein, 2001; Corkery & Silver-Greenberg, 2015). Many Christian therapeutic boarding schools in the USA are Teen Challenge programmes which work to ensure teenagers become model Christians, like the Thrive Girls Academy, which aims to “help girls transform into responsible, respectful, and gracious young women” (Thrive Girls Home, 2023; Columbus Girls Academy, 2017; Treasure Coast Boys Academy, 2023).

A decade later, Independent Fundamentalist Baptist preacher and Texan radio host Lester Roloff “innovated a method for teen reform centered on the near complete domination of

students—marked by hours of scripture memorization, self-paced school instruction and intense chores” (Franck, 2022). Roloff had established ‘successful’ adult residential programmes, but his work with teens started with the Rebekah Home for Girls, founded in 1967 (Colloff, 2001). In the Roloff Homes, students were subject to shame-based interventions, constant gospel, and brainwashing, a charge Roloff only half-denied, “It’s a washing, but it’s called bloodwashing and heartwashing” (Reginald Stuart, 1982). The homes restricted and censored contact with families, used solitary confinement, deprived teens of adequate nutrition, and subjected them to corporal punishment; “there’s nothing wrong with handcuffing a girl to keep her from going to hell,” Roloff claimed (Reginald Stuart, 1982; Crewdson, 1979; Joyce & Mechanic, 2011). Texas shut down its operations, so some relocated to a different state, and many of the ‘homes’ transitioned to being called ‘academies’, i.e. the Texas-based Anchor Home for Boys became the Montana-based, and then Missouri-based Anchor Academy (Chammah, 2014; Joyce, 2011). When George W. Bush became the governor of Texas, he welcomed them back to the state (Chammah, 2014). The Roloff Homes have remained influential in contemporary Christian therapeutic boarding schools (Piore, 2023).

The ‘birth of the troubled teen industry’: Synanon and CEDU

In 1958 Santa Barbara, California, the United States’ first self-help therapeutic community was founded: Synanon (De Leon & Unterrainer, 2020; Kaye, 2020). The founder Charles E. “Chuck” Dederich, was a former alcoholic who had recovered through the Alcoholics Anonymous (AA) twelve-step programme (Morantz, 2009). Inspired by his experience, Dederich sought to start a new recovery movement for drug-addicted adults run by ex-addicts, not medical professionals. Unlike AA, Synanon was a residential community that relied on a “group process that used confrontation and ridicule to force participants to confront their moral defects. The confrontations took place in an intense, rule-governed familial environment that supported addicts’ efforts to replace old, maladaptive defences with new habits and coping patterns” (Clark, 2017, p. 11). Synanon was famous for its use of ‘the game,’ high-intensity confrontational screaming group sessions, these were supposed to encourage peer accountability and emotional catharsis (Baron et al., 2003; Sugarman, 1970). The expectation was for members to withdraw completely from drugs, illicit or prescription, and adhere to a strict new system of rules and peer accountability (Szalavitz, 2007).

The programme claimed resounding success and became famous within a few years, attracting endorsements from politicians, celebrities, psychologists, and even the Black Panther Party (Kaye, 2020, p. 89). Synanon became a model for the treatment of drug addiction outside of the medical model approach. Dederich was labelled the “father” of an alternative therapeutic movement powered “by the innovative genius of one powerful, charismatic figure” (Rachman & Heller, 1974, p. 393). It was criticised for its highly confrontational tactics, use of humiliation, authoritarian leadership, and brainwashing (Morantz, 2009; Ottenberg, 1981). In the 1970s, the therapeutic community became a religious cult under the name of the Church of Synanon and collapsed following a high-profile lawsuit and attempted murder (Aron, 2018; Morantz & Lancaster, 2013).

In the 1960s and 70s, graduates of Synanon, as well as some non-addict Synanon admirers (‘squares’), began to open spin-off programmes (Bloch, 2020; Clark, 2017). New

communities and programmes were founded by graduates of Synanon, and then by graduates of their programmes, and so on, creating generations of iterations:

“By the mid-sixties, other programs modelled after Synanon had begun to spring up around the country. Most of these programs were started by original members of Synanon who ‘left the fold’ or by non-addicts who had been involved in Synanon as observers in the early days. When new programs were started, ultimately, members of these programs left to start yet another round of t.c.’s. Thus, in the New York City area, early Synanon people were instrumental in setting up Daytop Village and Phoenix House; in turn, Daytop people began Liberty Village in New Jersey and Gateway House in Chicago, and ex-Phoenix members began SERA and Veritas in New York. The t.c. movement, then, has grown with little ‘professional’ input and, rather like a religion, has been handed from ‘father’ Dederich to ‘sons and daughters’ who then spread the work throughout the country.” (Rachman & Heller, 1974, p. 394).

Starting in New York with Daytop Village (1963) and Phoenix House (1967), Dederich’s experimental approach to drug treatment spread across the country and snowballed from one replica recovery community to another (Clark, 2017; Sugarman, 1970).

In 1967, Mel Wasserman, a Palm Springs, California furniture salesman, opened a therapeutic boarding school. Wasserman was not a mental health professional or a drug treatment specialist, and he was not a former addict, but he attended Synanon as a supporter of Dederich’s treatment philosophy (Bloch, 2020). As a businessman, Wasserman identified the lack of drug addiction treatment for youth as a potentially lucrative market and opened CEDU Educational Services (pronounced See-Do, their motto being “See yourself as you are and do something about it”²) (The CEDU School, 1988). Borrowing from what Wasserman saw at Synanon, CEDU had group confrontation sessions called ‘raps’ and ‘propheets’ that could last for hours or days at a time (Scheff, 2008-2010; Safran, 2018). CEDU implemented a token economy of privilege levels, required conformity from students, relied on peer surveillance and accountability, and was run by staff without healthcare qualifications (Bonnie, 2015; Hilton, 2023). CEDU started as a single therapeutic community that would expand to around a dozen facilities, reportedly making over a million dollars a year before it eventually closed (Bloch, 2020; Szalavitz, 2006).

Aspects of CEDU and Synanon remain in the troubled teen industry today. Dozens of therapeutic boarding schools were started by CEDU programme staff, and, like Synanon, many off-shoots came to fruition and led to more off-shoots (Mohr, 2009). The profitability of CEDU identified ‘troubled teens’ as a lucrative market. Further, many of the approaches used at CEDU are techniques and principles that have remained present in the industry, adapted over the decades. The ‘raps’ and ‘propheets’ are foundational to what would become known as ‘attack therapy’, interventions that compel students to scream at each other, make accusations against each other, and engage in confessional ‘emotional catharsis’ (Szalavitz, 2006; Gilpin, 2021; Bratter & Sinsheimer, 2008). The privilege level

² CEDU is said to have been an acronym for Charles E. Dederich University, named after the Synanon founder. The origins of the name are contested (Safran, 2018).

system, also known as a token economy, is a feature common throughout most therapeutic boarding schools, and sees students have to earn their 'right' to access basic privileges and social communication (Mohr et al., 2009; Chatfield, 2019). Peer accountability and surveillance remain common features (Mooney & Leighton, 2019). Although it appears the industry is shifting to become increasingly medicalised, and many now have licensed staff, some remain without this, and many are understaffed due to profit-driven cost-cutting motivations (NATSAP, 2023f; Larson, 2023b). The industry has evolved but it has not shaken these early routes.

Chapter three: Theoretical approach

Ontology and epistemology

My research is grounded in a broadly feminist interpretive approach that does not seek to establish a singular 'reality' or 'truth' (Stanley & Wise, 1993). Reality and truth are labels we have given to socially revered world interpretations. There are 'real' events, people, places, and broader phenomena, but we will experience, remember, and retell these from our own vantage points. There is no objective way to interpret the world because reality is not a neutral entity we can access; it is a social process of meaning-making (Harding, 2004). 'Knowledge' is interpretations we have personally and collectively designated valuable. Knowledge is constructed by and through power (Haraway, 1988; Collins, 1991; Dotson, 2011). I am necessarily shaped by these power relations, including my status as a scholar within the academy. I have not sought to establish a singular 'truth' in this thesis. Instead, this thesis is a layering of interpretations that weaves a multiplicity of truths. Readers continue this interpretive process as they interact with the words on this page. I invite this weaving together, this listening, witnessing, and telling, as a form of subversive knowledge production.

Mad Studies

Mad Studies is an interdisciplinary field of activist scholarship that challenges how 'madness' has been constructed, pathologised, and controlled in society (Reville, 2021; Aho et al., 2017; Daley et al., 2019). Mad Studies is rooted in the knowledge and advocacy of psychiatric survivors, mental health service users, and those subject to broader mental health-related coercive community and service interventions (Costa & Ross, 2023). Mad Studies is a liberation-oriented field of study that aims to dismantle the social structures and social norms that are oppressive towards mad people and those who have been labelled as 'mentally ill', especially but not exclusively, harmful approaches found within the psy complex (psychiatry, psychology, social work, and related fields) (Spandler & Konstantina, 2019; Bruce, 2021). The intention is not to deny or minimise distress experienced by individuals; rather, Mad Studies seeks to understand these experiences as part of social phenomena, locating madness and psychological distress "within wider historical, institutional, and cultural contexts" (Menzies et al., 2013, p. 3). As connected to the Mad Pride movement, Mad Studies reclaims and re-envision 'madness' from individual pathology to a framework of collective resistance and radical self-identification (Reaume, 2019; Diamond, 2013; Snyder et al., 2019).

Through the lens of Mad Studies, the troubled teen industry can be understood as an oppressive institution that pathologises youth deviance, commits harm in the name of care, and denies 'troubled' young people's epistemic agency. 'Epistemology' refers to the theory of knowledge, and 'epistemic injustice' describes the harm of being socially undermined as a producer of knowledge (Fricker, 2007; Medina, 2021). I use the term 'psychiatrisation' to describe social processes that label 'deviant' cognitive-emotional embodiments and expressions as pathological problems that require medical or 'therapeutic' intervention (Kecmanović, 1983; Beeker et al., 2021). In the troubled teen industry context, 'trouble' is a

particular form of psychiatrisation, a ‘madness’ label imposed on children and young people. ‘Troubled’ is a disruptive madness that defies the status quo of a sanist-adultist society. In Mad Studies, ‘sanism’ is a term used to describe interpersonal discrimination as well as broader cultural, social and systematic subjugation of psychiatrised people (Perlin, 2013; Poole, 2012). Adultism refers to the social oppression of young people and children and the socio-cultural centring of adulthood (LeFrançois & Coppock, 2014). Adultism and sanism are part of broader processes that devalue the personhood of young psychiatrised people. Consequentially, ‘troubled teens’ are positioned as without legitimate insight into their own experiences and lacking the capacity to act according to their needs.

‘Troubling’ as a social process

I use the term ‘troubled teen’ to reflect a social phenomenon of labelling, rather than as an individualised pathological problem. In American English, to be ‘troubled’ can be defined in several ways: worried, in a state of mental distress, or “characterised by unrest, esp. social unrest by troubled youth” (Collins Dictionary, 2023b). The ‘troubled’ are disturbed or disturbing. The adjective describes a problem- an internal state of emotional duress, or a disruption to the social order. The term ‘troubled teen’ connotes a young person seen to have problems or to be causing problems. The term attributes problems as being within the individual, not only does the young person have or cause problems, but they have become framed as *the* problem; the teenager does not *have* troubles, they *are* troubled. ‘Troubled’ becomes a defining feature of a young person’s character. When considered sociologically, to be ‘troubled’ says at least as much about the people and society who label as those who are labelled.

The ‘troubled teen industry’ creates trouble by constructing a wide span of teenage emotions and behaviours as troublesome. Broadly speaking, we can understand ‘troubled teens’ as young people whose emotional and behavioural expressions have been a source of concern to those with authority over them. The ‘trouble’ is not in the teenager, it is in the expectations of authority. Deviation from these expectations is troubling to those in power. We may better understand the ‘troubled teen industry’ not as one serving ‘problem’ young people but as a mechanism of social control, an intervention imposed on deviant youth, on those who are ‘in trouble’. When a young person is in ‘trouble’, “they are in a situation in which a person in authority is angry with them or is likely to punish them because they have done something wrong” (Collins Dictionary, 2023a). Conveniently, the troubled teen industry labels young people as troubled and then offers itself as the solution to fix the problem it has just constructed, and for a profit.

Mad methodology and survivor-led research

At the core of Mad Studies is the liberatory potential of mad people telling, and reclaiming, our stories (Costa et al., 2012). In defiance of the biomedical model of mental distress, this is more than just acts of speaking and being heard. Mad methods disrupt the ways in which biomedical research processes have been built to meet the needs of knowledge generated about us, not for us. Building on feminist standpoint theory, Black feminist thought, and the disability rights movement, mad methods unsettle traditional research values and frameworks (Medina, 2013; Collins, 1991; Charlton, 1998; hooks, 2014). Mad methodology does not seek value-neutral and purportedly unbiased research as the ‘gold standard’

(LeFrançois & Voronka, 2022). Our emotions are not diminished as an obstacle to reason, and our personal reflections have a meaningful presence in mad and survivor research (Page, 2017). Our experiences of madness and psy institutionalisation are drawn on as guiding insight in research design, data collection, and analysis (Landry, 2017; White, 2022). Survivor-led research can be understood as “the systematic investigation of issues of importance to survivors, from our perspectives and based on our experiences, leading to the generation of new, transferable knowledges” (Sweeney, 2016, p. 37). As part of Mad Studies, I conceptualise mad methodology as a research orientation that centres the voices of mad people, disrupts dominant sanist research values, and produces knowledge that furthers mad and cross-liberatory movements.

La Marr Jurelle Bruce describes mad methodology as knowledge generation and world-making built on compassion and defiance, as an oppositional force to emotionally detached, insular and supremacist, rationalist logic:

“Most urgently, mad methodology primes us to extend radical compassion to the madpersons, queer personae, ghosts, freaks, weirdos, imaginary friends, disembodied voices, unvoiced bodies, and unReasonable others, who trespass, like stowaways or fugitives, in Reasonable modernity. Radical compassion is a will to care for, a commitment to feel with, a striving to learn from, and an openness to be vulnerable before a precarious other, though they may be drastically dissimilar to yourself” (Bruce, 2021, p. 10).

This articulation of mad methodology is more than listening to the voices and experiences of mad people, beyond the reclamation of personal or collective narrative, it is an invitation to radically re-envision society and our relationship to each other. In this way, mad methodology can be understood as more than a research process, it is an ethos of living and caring differently.

A case for madness: Case studies as counter knowledge

The troubled teen industry has long relied on parent and student testimonials and inspirational case studies highlighting their successes (Bratter & Sinsheimer, 2008). The clinical case study is written from the vantage point of the professional, to meet the goals of the institution. These can be produced without collaboration, and potentially without the consent or knowledge, of the person whose experiences are being narrated (Yin, 2014; Solomon, 2006). Not only does this speak over us as mad people, but the institution-controlled clinical case study also represents a demonstratable financial conflict of interest. Our stories have been told for their purposes, our trauma spun for their profits. I have ‘troubled’ the industry-controlled case study and repurposed it to centre the insights of mad people, from a clinical gaze with no input from those they are writing about to a survivor-led and collaborative crafting of counter-narratives.

The values that underpin case study research have the potential to uniquely align with those of Mad Studies. Case studies are not driven by an ambition to categorise people’s life experiences into a rubric of ‘generalisable’ labels (Flyvbjerg, 2010). Instead, my ambition for the ‘survivor-led case study’ is to explore in-depth the complexities and social context of each individual. Unlike psychological studies that seek to ‘control’ variables, the survivor

case study seeks to understand the multi-dimensional and complex realities of people's lives (Siggelkow, 2007). While case studies have been criticised as lacking validity due to the potential for researcher bias, mad methodological approaches encourage acknowledgement and critical engagement with the researcher's standpoint. The smaller number of participants typically used in case study research presents an opportunity for collaboration and participant feedback (Tight, 2017; Slettebo, 2021). Survivor-led case study research emerges in opposition to the values of positivist clinical research, it deconstructs detached and reductive approaches and instead aims for complex survivor storytelling and theory development.

Reflexivity, intersectionality, and survivor-research

When we produce counter-knowledges, we never do so in isolation or from any singular vantage point. I am not simply a survivor-researcher, a mad and disabled academic; I am positioned within multiple interlocking sites of privilege and marginalisation (Yuval-Davis, 2006). Intersectional feminism helps to understand ways "race, class, gender, sexuality, ethnicity, nation, ability, and age operate not as unitary, mutually exclusive entities, but as reciprocally constructing phenomena that in turn shape complex social inequalities" (Hill Collins, 2015, p. 2). This requires critical reflection on my social location and privileges, my relationship to the data, the power of the researcher position (as well as the vulnerability of survivor-researchers in the academy), and how these influence interpretation and theory generation (Sultana, 2007). Gray describes reflexivity as an ongoing process that "involves a turning back of inquiry on the formative conditions of its production by variously addressing questions of the researcher's biographical relationship to the topic, the multiple voices in the text, different potential readings and the instability between the research text and the object of the study or representation" (Gray, 2008, p. 393).

Rather than shy away from how my social standpoint and lived experience impact research, "survivor research is conducted from an explicit standpoint that is not hidden or obscured but foregrounded and interrogated" (Sweeney & Beresford, 2020, p. 1190). Although this research was conducted from a survivor perspective and participants have been involved in parts of the research process, there remains a power imbalance between me as 'the researcher' and participants as 'the researched' (Davidson, 2001). I recognise that while I am a survivor of the troubled teen industry, every person's experience is different. I have not experienced many of the abuses and formal interventions articulated by other former students/survivors in this thesis. For example, I have not been 'forcibly transported', I never attended a wilderness therapy programme, and my stay in the therapeutic boarding school was for a relatively short period. My experience in the programme was shaped by the time period in which I attended, the early 2000s, my social identities at the time, as well as the vantage point of my identities today as an adult. These include being white, secular Jewish, middle-class, American and British, a woman, LGBTQ+, mad, and disabled. However, acknowledgement alone does little to affect change (Folkes, 2022). "Confession" of privilege and statements of reflexivity are not singular acts or redemptive endeavours, reflexivity is a deep and ongoing commitment that requires transparency and accountability (Pillow, 2003; Murray, 2020, p. 412).

Survivor-researchers have, by virtue of being 'survivors', experienced marginalisation and structural subjugation, but many who enter professional and academic roles have social

privilege in terms of race, class, and nationality. White and middle-class people like me are more likely to be centred in the representation of survivors' experiences. Known as 'elite capture,' privileged people in marginalised groups tend to exert power over the group's dominant narrative, political direction, and allocation of resources (Táíwò, 2022). Often unintentionally, survivor-researchers can reproduce epistemic injustice against marginalised survivors while undertaking work that purportedly uplifts survivors' voices (Voronka, 2016; Gorman et al., 2013; Bell, 2016). Therefore, it is important for researchers to critically reflect on how we engage with our 'lived experience' and to ensure we do this in ways that do not make assumptions about the experiences of others. This requires us to consider how our biases may shape the research processes, who the research benefits, and ways that it may cause unintended harm and erasure.

Navigating language and my survivor identity

I am a former therapeutic boarding school student, one of the thousands of former 'troubled teens'. But I was not really a 'student'. I was not an empowered 'consumer', nor a 'client' procuring services. Not a passive 'patient' in receipt of care. I was not a 'service user', I did not use the service, the service used me. Today I call myself a 'survivor' of the industry, but back then I was just a teen stuck in an institution trying to find my way out. I do not fit, nor do I wish to, a narrative of having 'overcome' my experiences. As disability justice activist-author Leah Lakshmi Piepzna-Samarasinha describes:

"I do not want to be fixed if being fixed means being bleached of memory, untaught by what I have learned through this miracle of surviving. My survivorhood is not an individual problem. I want the communion of all of us who have survived, and the knowledge. I do not want to be fixed. I want to change the world" (Piepzna-Samarasinha, 2019, p. 119).

I am proud that I survived, but I do not celebrate that I lived through conditions which required surviving. I am not proud of how a system drove me mad and then took away my rights because I was mad. A system where I could only be 'sane' if I was agreeable to authority. I do not celebrate the hardship, pain, and trauma. For me, mad pride is in collective resistance; community and connection formed around aspects of ourselves many of us were told needed to be contained or overcome.

I am 'mad' because I want my experiences and identity to disrupt business as usual. My identity stands in opposition to the systems which oppress me. For me, identifying as 'mad' is an act of refusal. I refuse to be 'sane' in a world which normalises cruelty. If rationality represents a world where the prosperity of one group is tied to the exploitation of another, if being productive and functional is the perpetuation of this system as normal, then I want to refuse it. Perhaps if we were all crazy and maladaptive, we could live in a better, fairer, kinder world. Yet I am, we are, bound up in this system which we cannot individually remove ourselves from. My refusal is always partial, as being part of these social structures is an inescapable aspect of living (as well as of dying). My madness is aspirational defiance, a refusal necessarily incomplete, but nonetheless trying.

Survivor-led research and mad crip time

Chronic illness, mental distress, neurodivergence, and disability more broadly impact how we navigate space and time. Time can feel longer or shorter depending on how we feel,

what we are doing, and what is happening in the world around us (Noguchi, 2022; Samuels & Freeman, 2021). Temporal expectations are part of the research endeavour and therefore are important to mad methodology. 'Crip time' proposes a clock guided not only by the hour but by the embodied experience. Allison Kafer writes, "Rather than bend the bodies and minds to meet the clock; crip time bends the clock to meet disabled bodies and minds" (Kafer, 2013, p. 27). Crip³ time encourages pacing and embodied listening as a practice of resistance and self-compassion (Hersey, 2022; Kafai, 2021). This is distinct from the neoliberal approach to taking breaks to improve overall productivity; crip time does not espouse pacing for the sake of profit (Kim & Schalk, 2021). Crip time critiques how ableism is reproduced by how time has been organised in our society. In a capitalist matrix of domination, normative time reproduces multiple intersecting oppressions, including colonialism, racism, classism, and cisheterosexism (Bailey, 2021; Collins, 1991; Samuels & Freeman, 2021). Crip time poses a bendiness to how we interpret time, a reorientation of our relationship with time (Price, 2021).

I build on the work of crip time to envision 'mad crip time'. While 'crip' includes a range of disabilities and can be understood as an umbrella term, I discuss 'mad' and 'crip' perspectives as overlapping but not interchangeable. I have added mad to specifically attend to the trepidations of time I experience as a survivor-researcher living with depression, trauma, and fluctuating fatigue. Survivors, as people who have lived through and with trauma, experience time and place with complexities that unhinge chronology and disrupt the concepts of then and now. Morrigan explains, "As a person living with complex trauma, I do not experience time as a straightforward, orderly procession from the past, through the present, to the future" (Morrigan, 2017, p. 50). Trauma memories can emerge as an entanglement of time as our pasts are embodied in the present. Depression, trauma, and fatigue integrate to create fluctuations of energy and concentration, unstable temporalities that can be unpredictable and unyielding.

As mad and crip survivor-researchers, we conduct research, process personal and collective traumas, and fight for liberation. Yet we are somehow not supposed to be exhausted by this. We are not supposed to have violence of the past or the present be part of our lives or 'get in the way' of what we do. While our trauma is valuable to the university when it produces research papers, it is framed within its bureaucratic structures as a personal issue/deficit when coping with trauma requires more time and resources. Trapped in what Price calls the 'accommodations loop', when I need 'extra time', I have to prove I am 'sick' and spend my time and energy completing proformas for administrators I will likely never meet (Price, 2021). For neurodivergent, mad, chronically ill, and disabled/crip academics, we

³ 'Crip', like 'mad', is a reclaimed term and radical approach within Critical Disability Studies (McRuer, 2018). I engage in crip scholarship and, in some contexts, I include my experiences under a crip theoretical framework, but the term does not feel like mine to reclaim. As a form of the word 'cripple', crip still carries specific connotations relating to visible mobility impairment (Kafer, 2021). I often pass as non-disabled. Therefore, I am not targeted for some forms of discrimination and violence. I understand the term is premised on collective reclaiming, but it feels uncomfortable and appropriative for me. It also has a very different meaning in parts of America that the ivory tower rarely acknowledges: the Crips are one of the country's largest gangs (Bone, 2017). I grew up relatively sheltered as a white person in a middle-class New Jersey suburb, but the Bloods and Crips were on the periphery of my hometown, and this association makes self-identifying with the word feel very different.

are constantly against the tide in a system designed for reliable efficiency and competitive overworking (Brown & Leigh, 2018).

My depression, anxiety, ADHD, and fluctuations of chronic fatigue mean I cannot take for granted the capability to work. Sometimes deadlines are helpful for organising my interested-in-thinking-about-everything brain; there are times I can (and want to) 'push through' and feel a sense of achievement. Other times I can push too hard and descend into anxious panic or trigger a fatigue flare-up. When and what is 'too much' lacks consistency in my life, the crip-neurodivergent-mad bodymind experiences time with a sense of precarity. As Ellen Samuels describes:

"For crip time is broken time. It requires us to break in our bodies and minds to new rhythms, new patterns of thinking and feeling and moving through the world. It forces us to take breaks, even when we don't want to, even when we want to keep going, to move ahead. It insists that we listen to our bodyminds so closely, so attentively, in a culture that tells us to divide the two and push the body away from us while also pushing it beyond its limits. Crip time means listening to the broken languages of our bodies, translating them, honouring their words" (Samuels, 2017).

I am not going to produce a PhD in the same way or timescale as other students. I can try all I want, but I cannot neoliberal work ethic myself into being able-bodied, so I cannot be productive according to the standards set by and for abled bodyminds. In ways purposeful and reluctant, I have to set a different pace. While it was not my deliberate choice and has come at a personal and financial cost, a slow scholarship opened a deeper engagement with my work. I feel connected to this work in a way that would not have been possible if my central task had been completing the thesis 'on time'.

Chapter four: Research methods

The research has focused on retrospective accounts of adult former therapeutic boarding school students. The study consists of three successive stages: an initial online questionnaire, followed by in-depth interviews, and finally, case study summaries and participant feedback processes. The research integrates qualitative and quantitative methods (Bryman, 2006). This chapter summarises the research methods used in the study and outlines the research design, data collection, analytical processes, ethical implications, and research limitations.

Research aims

The research has four central and interconnected aims:

1. To produce knowledge that centres the perspectives of former therapeutic boarding school students.
2. To document and analyse former students' experiences before, during, and after their time in therapeutic boarding schools.
3. To analyse the role of institutional culture in the experiences of former students.
4. To increase awareness about troubled teen industry abuse, maltreatment, and human rights violations.

Research questions

1. How do former therapeutic boarding school students interpret and describe their experiences before, during, and after their time in the troubled teen industry?
2. How did institutional culture impact the former students' experiences of therapeutic boarding schools?

Research stages

This multi-stage research employed a sequential approach, starting with an online questionnaire to collect data from a larger sample. A subsample of these participants was then invited to an interview, providing more detailed insights. From the interview participants, a further subsample was chosen for case study analysis, and participants were invited to give feedback on their case studies. The three stages are outlined in the flowchart below (Figure 1). The multi-stage design enabled a comprehensive exploration of the research topic with diverse data sources and perspectives.

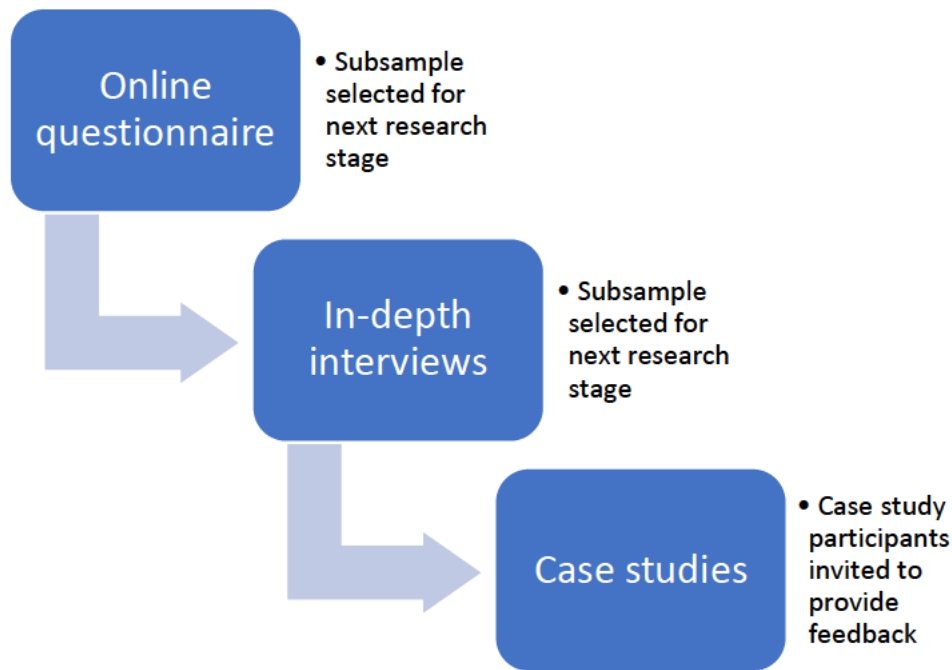


Figure 1- Flowchart on research stages

Research ethics

Research participation was voluntary and confidential. The study was open to any former therapeutic boarding school student who was 18 or older and no longer attending a ‘troubled teen industry’ programme. The rationale for these requirements was to simplify the university ethics review process. Secondly, due to legal requirements and social work ethics, if a minor or a person currently inside a programme were to have disclosed experiences of abuse, I may have been required to report this; thus, I would not have been able to maintain a commitment to confidentiality (Surmiak, 2020). Before participation, information clearly outlined the purpose of the study, what to expect from research participation, potential risks and benefits, and how the research may be used in the future (Bryman, 2001). They were informed that they had the right to stop participation at any point without negative repercussions. I provided contact information for myself and my supervisor, where participants could direct queries or complaints. Participants had to read and confirm agreement to the conditions before commencing the questionnaire and again before the interview.

The doctorate was funded by the Scottish Graduate School of Social Sciences, Economic and Social Research Council (ESRC) (Grant number 1777220). The ESRC are a UK government research funding body with no known links to the troubled teen industry. In line with ESRC requirements, responses have been stored in highly secure, GDPR-compliant online data management systems (Economic and Social Research Council, 2016). Responses were anonymised during the analytical process. The research was approved by the ethics review board at the School of Social and Political Science, University of Edinburgh.

Retrospective accounts

The research has focused on adult reflection on youth experiences in therapeutic boarding schools. The retrospective research approach was chosen for several reasons. Practically and ethically, it would have been problematic to access current therapeutic boarding school students. Institutional gatekeeping of student access would allow programme staff to have the power to discern whom I was allowed to speak to and on what conditions. Student communications with the outside world are typically restricted and monitored by staff, and this could compromise participant safety (Chatfield, 2019). I would not have been able to ensure the confidentiality of students if questionnaires or interviews were conducted inside schools where staff could, overtly or covertly, observe their responses. Research pre-approved by therapeutic boarding schools would have affected participants' confidence in the research process as independent scholarship.

Adults reflecting on their experience as youth inside these facilities was seen as valuable insight in and of itself. Insights into the long-term impact of treatments can only be ascertained by researching those who are no longer in the programmes. The retrospective approach created the opportunity to conduct research with former students across several generations who attended programmes at different times. I recognise that adults' perspectives differ from youths and that this will impact their interpretation of the TBS experience. Psychological and physical distance from their time in the programme allowed former students more time to reflect on and process their experiences. Adult reflections will have also been influenced by changes in culture and information access, such as media coverage of the industry and access to internet forums. Our self-understandings are constantly shifting, "All stories are located in flows of time. They are never fixed or static things" (Plummer, 2013, p. 214). The dynamic interpretive implications of retrospective accounts provide insight into how former students make meaning of their experiences. However, an important limitation of retrospective accounts is 'survival bias,' former students who have died cannot participate, and former 'troubled teens' appear to have a high rate of suicide and drug overdose deaths (Mooney & Leighton, 2019, p. 616).

Research with psychiatrised and traumatised populations

Social research has often excluded people with active, complex, or extreme experiences of mental distress, especially psychosis and hospitalisation (Lieberman et al., 2006; Cuénod & Gasser, 2003). There is often a presumption of vulnerability, incapacity to consent to research, and diminished credibility as knowers (Palk et al., 2020; Kurs & Grinshpoon, 2018). The framing of psychiatrised people as 'vulnerable' and in need of special protective measures deflects from the researcher's responsibility to represent the experiences of marginalised people and conduct research in an ethical and supportive manner. An individualistic framing of vulnerability also fails to address the ways in which people are systematically vulnerablised (Carel & Kidd, 2021). The construction of mad people as principally 'vulnerable' overlooks how resourceful and insightful psychiatrised people can be (Carpenter & Conley, 1999). As Ryoa Chung summarised, "We must reject an essentialist conception of vulnerability that reflects a reductive view of those considered vulnerable and fails to question first the norms and socially constructed barriers that cause them harm" (Chung, 2021, p. 202). When researchers exclude mad and psychiatrised people from participation, they remove opportunities for us to be heard, shape research praxis, and influence policy and practice.

It is crucial, however, to acknowledge that research has the potential to be emotionally demanding, triggering, and disempowering for participants. Research that relates to histories of abuse and traumatic memories must consider the potential to harm participants (Helman, 2022; Reamer, 2010). As a social worker who has specialised in supporting abuse victims/survivors, I understand the complexities of trauma and the importance of responding compassionately, affirmingly, and carefully. To minimise the risk of harm, I did not ask probing questions, participants had the option to end the interviews or questionnaires at any point, and I made it clear to interviewees that they could choose what they felt comfortable to share (Becker-Blease & Freyd, 2006; Eriksen, 2017). The interview information sheet explains,

“You can choose what you do and do not share in the interview. There is no pressure to discuss or describe anything you do not want to talk about. However, the research topic may bring up difficult emotions and memories. You may pause or stop an interview at any point. If you would like additional support after the interview, I will be available to discuss support options” (Interview information sheet, Appendix 2).

I anticipated that the research process had a high potential to raise difficult memories or to be upsetting. However, difficult is not synonymous with harm; for some, talking about abusive histories may be difficult but also healing (Haggerty, 2004). Multiple participants across all research stages reflected this sentiment. I trusted the participants to judge what they felt comfortable and safe to share.

Research definitions

Defining the troubled teen industry is complex and contested. While the term ‘troubled teen industry’ is commonly referred to, there is no consensus on how to define specific inclusion or exclusion criteria. The industry is a nebulous concept; it can be seen as all congregate residential programmes for youth or as a specific set of private parent-pay operations. There is tension between the need for specificity and the desire for a broad understanding of pathologised youth confined in residential institutions. The lack of definitional consensus has served the industry's interests- it is hard to regulate what you cannot define. In the years that I have been researching the troubled teen industry, I have not been able to establish definitions of the industry or of therapeutic boarding schools that perfectly encapsulate the variety of programmes to which I believe the labels ought to apply. I have included several definitions to help orient readers. I raise definitional dilemmas in the hope that this can contribute to ongoing dialogue and debate.

Therapeutic boarding schools

Therapeutic boarding schools (TBS), also known as ‘emotional growth boarding schools’, are boarding schools or academies that seek to reform young people (primarily 13 to 18-year-olds) who have been labelled with psychological health problems. These labels may be formal diagnoses from licensed healthcare professionals or informal opinions of parents, teachers, and industry advisors. A formal diagnosis is not always a prerequisite for TBS admission. For my research, therapeutic boarding schools have been defined with a set of inclusion and exclusion criteria outlined below. The criteria were designed to distinguish

therapeutic boarding schools from other institutions, such as outpatient services, hospitals, wilderness therapy, and traditional boarding schools. The definition has been used for the purposes of research and is not a definitive guide to what is or is not a therapeutic boarding school. This is an under-researched and under-theorised topic, and I encourage future refining of definitions.

Foundational criteria:

- A long-term residential programme with the specific aim to accommodate and reform teenagers considered to have mental health, behavioural, and/or substance misuse problems.

Additional criteria- the programme has at least five of the six following features:

- Young people board overnight on campus, including on most weekends.
- There is permanent on-site accommodation.
- The programme operates 365 days a year.
- Young people have restricted contact with the outside world.
- There is a therapeutic group work component.
- There are taught classes on an average weekday.

This is a revised and more flexible version of the original research definition and criteria, which had previously required meeting all seven features to be included as a TBS (this is discussed in more detail later in the online questionnaire chapter). I amended the criteria as it became clear during the research process that the original criterion would exclude some programmes which ought to be considered therapeutic boarding schools.

There remain several considerations which pose important challenges to how we define what constitutes a therapeutic boarding school. Ongoing definitional questions include:

- Are therapeutic boarding schools only private parent-pay programmes? If so, do they still count if some students are state-funded or state-referred? How would we define privately operated programmes that have primarily state-funded students? Is funding a core issue for the troubled teen industry?
- Is there something specific about the troubled teen industry therapeutic or marketing approach? How would we define this, and would this remain relevant with changing trends over time?
- Would robust regulation require a broad-reaching legal definition? Programmes can be registered and advertised under various categories (schools, faith programmes, residential care); if we are too specific about the criterion, will regulatory efforts allow for loopholes and gaps in oversight? If we are too broad, do we miss specific issues relating to programmes with no state funding?

Troubled teen industry

I refer to the 'troubled teen industry' as a range of residential reform programmes marketed as treatments for 'troubled teens'. These include therapeutic boarding schools, residential treatment centres, and wilderness therapy programmes. Teen boot camps and LGBTQ+ conversion camps are also part of the industry, although they are not the focus of my research. More broadly, the troubled teen industry includes key roles outside of, but related

to, residential confinement: youth transportation services that forcibly take youth to the programmes, educational consultants who advise parents to send teens to these programmes, private equity firms that own troubled teen institutions, and others who directly profit from or are instrumental in referring to and detaining youth in troubled teen facilities.

Parent-pay programmes

Marcus Chatfield, a troubled teen industry survivor-researcher, specifies troubled teen industry programmes as parent-pay programmes (Chatfield et al., 2021). Parent-pay programmes have placements procured by parents/guardians who pay the fees. These are often high-expense private residential programmes that cater to middle and high-income families. Chatfield stresses the importance of specifying the payment source, “federal safety standards do not apply to parent-pay programs and some states provide no protective oversight or regulation of these teen treatment programs” (Chatfield, 2019, p. 45). For this research, I did not require participants to have gone to private parent-pay programmes. However, all but one interview participant attended programmes where their parents paid. One accessed state funding to attend, but this participant was in a TBS where most students were parent-pay. The precise number of parent-pay programme attendees is less clear in questionnaire data, but this also appears heavily weighted towards parent-pay. In effect, my research reflects private therapeutic boarding schools whose primary income source is fees paid by parents/guardians.

Troubled teens

‘Troubled teens’ are youth whom adults have labelled with emotional, behavioural or substance misuse. Such labelling can include official diagnoses, but it is not limited to this. I consider all those who have been through the troubled teen industry to be current or former ‘troubled teens’. I use the term ‘troubled teen’ to reflect the sociocultural labelling of young people rather than an individual pathology intrinsic to a person.

Former students

I use the term ‘former students’ to describe anyone who used to attend a therapeutic boarding school. This includes people who graduated from a TBS and those who left or were expelled from the programmes. Some former students have attended multiple programmes. I used the term ‘former students’ to include those with positive, negative, and mixed experiences of therapeutic boarding schools. At times, I write ‘former students/survivors’ to reflect that most participants had negative experiences, and many identified as survivors. I use the term ‘victims/survivors’ where participants have referred to themselves using this language. I have also used the term in reference to those who have been subject to child sexual abuse (be it in the troubled teen industry or outside of it).

Teenagers, young people, and youth

When I refer to teenagers, I refer to those who are 13 to 17 years old. In most US states, when a person turns 18 years old they have reached the ‘age of majority’ and are considered a legal adult (exceptions to this are Alabama: age 19, Nebraska: age 19, and Mississippi: age 21) (Cornell Law School, 2021). The broad category of ‘young people’ includes those under 13 years old as well as those who are 18. I use the term ‘youth’ in a sociological context that refers to cultural ideas of what it means to be young instead of a

specific and fixed age (Cree, 2010; Tyyskä & Côté, 2015). 'Troubled teens' are youth but are not always teenagers, as some are admitted before becoming teens, and some students may remain in the programmes beyond their 18th birthday. Students may be compelled to remain in troubled teen programmes even if they are legally old enough to leave, for various reasons, including family pressures and gaining high school diplomas. Reaching the age of majority does not guarantee access to the rights and privileges of legal adulthood for those who are institutionalised.

Staff and former staff

Staff and former staff are people who currently work or have worked for a therapeutic boarding school or other troubled teen industry programme, including those whose work has been in a voluntary capacity. Notably, some former students have become staff at troubled teen programmes. Therefore, the categories of 'former student' and 'staff/former staff' are not mutually exclusive. Staff can be registered healthcare professionals as well as those who do not hold relevant qualifications. Staff include owners of the programmes, social workers who may facilitate group therapy sessions or provide one-to-one support, teachers, as well as day staff and overnight staff who keep watch on the students. Some staff will be expected to fulfil multiple roles or have relatively undefined roles.

Online questionnaire

There is no national register of troubled teen industry programmes and no official data documenting who has attended therapeutic boarding schools. Much remains unknown about the 'troubled teen' population. To access this 'hidden population,' I designed an online questionnaire which was disseminated using a non-randomised snowball sampling approach (Shaghghi et al., 2011; Ellard-Gray et al., 2015). This involved promoting the questionnaire on social media, through listservs, as well as relying on word of mouth (Leighton et al., 2021; Darko et al., 2022). The questionnaire had two main objectives: firstly, to gain an understanding of the demographic characteristics and experiences of individuals who had previously attended therapeutic boarding schools; and secondly, to serve as a means of identifying potential interview participants for the next stage of research.

The questionnaire was designed and hosted using the survey platform Qualtrics. This platform was chosen because it has a user-friendly interface, supports a variety of question formats, and complies with GDPR data protection requirements (Qualtrics, 2019). The first page of the questionnaire functioned as a coversheet outlining what participation involved, the potential risks and benefits, that participation was voluntary and confidential, and that participants could stop the questionnaire at any point (Orton-Johnson, 2010). The questionnaire was not anonymous as part of its purpose was to provide the contact information necessary to invite participants to interview. The questionnaire's first page also included my email address for participants to direct any queries and details of a free and confidential helpline service. To begin the questionnaire, participants were required to confirm that they had read the information sheet, agreed to the terms, and were 18 years old or over.

The questionnaire was designed to take around 15 minutes to complete. Research indicates that shorter questionnaires and those in multiple-choice formats have improved participant

response rates (Fielding et al., 2008; Blaikie, 2009). Therefore, I asked a limited number of questions and prioritised questions I felt were most crucial for gaining an overview of the participant's background and experience. Multiple-choice formats such as drop-down menus and checkboxes were used to maintain brevity, with an 'other' option for participants to write custom responses (Hooley et al., 2012; Frary, 2016). Several open-ended questions were included in the questionnaire where I sought to gain more in-depth information (Pew Research Center, 2022). I placed word limits on responses to the open-ended questions; this was done to make the analytical process more manageable. The questionnaire was piloted and refined according to feedback before it was made public. According to Qualtrics' data, the aim to keep the questionnaire brief was successful, as the average amount of time participants took from start to finish was 12 minutes. A copy of the questionnaire can be found in Appendix 1 for reference.

I created a website with information about my research, including the aims and methods of research, and a link for participants to start the questionnaire. From survivor spaces I had previously been in, I was aware of some former students'/survivors' scepticism of 'outsider' research (Dwyer & Buckle, 2009; Islam et al., 2021). I anticipated some may be hesitant to participate because they are worried about their stories being misrepresented and they are cautious about unknown researchers who could have industry connections. I felt the best way to address this was to make more information about the research easily accessible to potential participants and to be clear about my motivations. I explained that I am a survivor-researcher looking to understand former students' perspectives, and I have no known financial connections to the industry. In addition to the questionnaire coversheet, this provided more background information for those who were seeking it. The main purpose of the website was to streamline information into one place so that it was easily shareable. The questionnaire was launched in May 2018.

I contacted various organisations and requested for them to share my research with their membership and listservs (Dworkin et al., 2016). These included troubled teen industry trade associations like NATSAP, and survivor-advocacy groups like the Community Alliance for the Ethical Treatment of Youth (CAFETY). I also created a Facebook profile specifically for research dissemination. I searched for Facebook groups that referenced therapeutic boarding schools or the troubled teen industry. I requested to join the groups and posted a link to the research website with a brief explanation of the study. Depending on the group's rules, I messaged the group moderators to ask for permission before posting (Kamp et al., 2019). The Facebook group sizes ranged from a few dozen to a few thousand members. I also promoted the study through my personal networks, including posting about it to my private Facebook account and on Twitter. I planned to post the research on Reddit, but when I went to do this, I saw someone else had already shared it on the 'Troubled Teens' subreddit. Information on the online questionnaire appeared to spread effectively by digital word of mouth.

The questionnaire was closed in 2020. I initially had planned to conduct a second round of interviews, and therefore I kept the questionnaire open as a relevant research tool. However, due to the Covid-19 pandemic, I decided not to conduct any further interviews. When the questionnaire closed to the public there was a total of 144 responses, 111 of which were completed. Of the total completed questionnaires, 96 were submitted in 2018,

the period when the questionnaire was being actively promoted. The questionnaire therefore predominantly represents the viewpoints of participants in the year 2018, as only a small number of questionnaires were submitted after this point. Most participants reported they came across the questionnaire on Facebook or Reddit. Many heard about the research through a friend, or from a link posted by a former student to a school-specific alumni/survivor page. The online questionnaire was successful in that it functioned effectively as a tool for follow-up interview selection and provided insight into the demographic backgrounds and experiences of over 100 former therapeutic boarding school students. The analysis of questionnaire results will be discussed in the next chapter.

In-depth interviews

In-depth semi-structured interviews were conducted with former students/survivors for the second stage of the research. A subsample of participants was invited to be interviewed based on their geographic location and availability to interview (Palinkas et al., 2015). In the summer of 2018, I travelled to three USA regions to conduct in-person interviews, the Northwest, Northeast, and Southwest. Within each region, I travelled to multiple cities or towns. Regions were chosen based on the number of participants in the area and my ability to travel to and within the region (i.e., flights, accommodation, public transportation, car hire). In addition to locations with multiple participants, I prioritised access to underrepresented groups (Campbell et al., 2020; Bryman, 2015; Cuadraz & Uttal, 1999). For example, within the Northeast region, I travelled 1 ½ hours by public transport to interview a participant from a low-income background. Several interviews were conducted over the phone or via Skype if this was the participants' preference or where an in-person meeting was not possible. Interviews lasted between an hour to two and a half hours. The interviews were audio recorded, transcribed, and anonymised. Sixteen interviews were conducted, including one pilot interview.

All participants were invited to interview via email and were sent an information sheet about what to expect in the interview, potential risks and benefits, and confidentiality (see Appendix 2). I specified that the interviews were optional, that they did not need to answer any questions they did not want to, and that they could stop the interview at any point. Where possible, I arranged to interview participants in public spaces with private rooms, such as a local library. This was logistically difficult as I had to find new locations in each city and town I travelled to, and it was one of the most time-consuming aspects of conducting interviews. In some circumstances, I agreed to meet participants in their homes or a café. Before each interview, the participant was asked to sign a consent form (see Appendix 3). If the interview was conducted remotely, I read through each statement and recorded their verbal agreement to the terms (UKRI, 2023).

The interview guide involved questions that focused on participants' experiences before the TBS, during their stay in the TBS, and afterwards (see Appendix 4). I designed the questions to be broad, non-judgmental, and phrased in ways that were not leading (Bryman, 2015). For example, "What was going on in your life before you entered a therapeutic boarding school?" As a semi-structured interview, the questions were a guide and conversation starter (Adams, 2015). The interviews did not always proceed in chronological before-during-after order, and not every question was asked of every participant. I would respond

to participants' answers with follow-up questions and clarifications. Some interviews were conversational, others more structured, depending on how the person answered my questions. Some participants had difficulty speaking about their experiences, including one who cried for most of the interview. I checked with them if they wanted to stop the interview or take a break, and I reassured them that they did not have to talk about anything they did not want to (Guillemin & Gillam, 2004). All stated that they wanted to continue the interview. As a social worker, I have experience and training in how to listen supportively to people who disclose abuse and trauma. I tried to listen empathetically, affirm their experiences, and show respect and gratitude for sharing their story (Gair, 2012).

Interviews and co-constructing memories

Interviews are an interactive process of co-constructing narratives (De Fina & Georgakopoulou, 2008). Each participant will have navigated their reading of me and the secondary audience they anticipate I will re-present their experiences to (Elliott, 2005). My responses to their answers and my emotional presence impact the participants' perceptions of me as a researcher (Moser, 2008). In part, this is influenced by power relations, by trust, by perceived shared experience (Ellard-Gray et al., 2015). It is also influenced by our internal senses- our belief in our own stories, our belief that our stories are important and ought to be heard, and how we have processed difficult memories and feelings (Andrews et al., 2013). Memory is not 'pure', it is a constant negotiation between our current and past selves, between the self and others.

This research is not a fact-finding inquiry; it is an exploratory study that seeks to gain insight into people's perspectives. I have taken a generally affirming stance to how I present participant's narratives, describing their experiences as 'real'. I have not requested documentation or 'proof' from participants to validate their accounts, although some volunteered these documents to me, and news coverage has corroborated some of the abuse recollections. Historic abuse often cannot be independently verified due to institutional cover-ups and abuse taking place behind closed doors, out of view from eyewitnesses and disappeared from official records. Rather than attempt to establish a definitive objective truth, I have sought to understand the accounts of participants as their subjective reality, in other words, as their truth.

All memory is subjective and is influenced by a 'past-present relation', our historical experiences are reconstructed through the lens of the present (Popular Memory Group, 1998, as cited in Plummer, 2001: 236). The participants who have come across my research are likely to have been part of former student/survivor community spaces, such as online discussion forums, which would have influenced their perception of historical events. I do not consider this 'outside influence' to reduce the reliability of their perception; conversely, it may facilitate more people speaking openly about their experiences if these have been validated through prior knowledge-sharing (Graham, 2007). While there is cause to reflect on how leading questions can impact people's accounts and recall, it would not be appropriate or ethical for me to speculate on the accuracy of participant's memories. In the context of psychiatrised people and victims/survivors of abuse, it is especially important that their accounts are believed and not portrayed as 'all in their head', as merely subjective fictions of the mad mind. Moreover, some of the most traumatic memories may be the ones participants are least likely to share (Becker-Blease & Freyd, 2006). What is not discussed

can be as significant as what is. I want to acknowledge the stories that are absent, the stories I did not hear and that you will not read. I hope they are heard one day.

Interview transcription

Each interview was transcribed in its entirety in a long process that took several months. I listened to each recording repeatedly; I would stop, rewind, slow down the audio, and listen to it again and again, and I strived to make transcripts for every interview as accurate as possible. Except for removing names, the interviews were transcribed verbatim. It is, however, important to recognise that ‘verbatim’ transcription processes remain subject to researcher influence in how audio is translated into written word (Lapadat, 2000). Initially, I included each ‘hmm’, ‘um’ and ‘uh’ and words accidentally repeated or stumbled over. However, I later changed this approach and removed filler phrases and repeat words unless these were seen to be important to convey the original meaning, an approach sometimes referred to as ‘naturalised’ verbatim (McMullin, 2023, p. 141). As an example, an original verbatim transcript reads “I have ADD as well, um, and ostensibly ODD, oppositional, but I don’t know where, if, I was diagnosed with that by the school itself to get me there”. A naturalised verbatim version reads “I have ADD as well and ostensibly ODD, but I don’t know if I was diagnosed with that by the school itself to get me there”.

The change in transcription approach was prompted after a participant who had requested to review his transcript commented that it seemed as if he was inarticulate (Hagens et al., 2009). Sally Thorne explains the potential pitfalls of transcribing verbatim,

“Verbal material often has stops and starts, grammatical errors, partial words, and/or repetitions as a person gathers their thoughts and tries to find the best way of communicating it to an interviewer. If you report on the material ‘verbatim,’ including all of the ums, and ahs, and problematic speech parts, your reader is likely to get lost in the vernacular and miss the underlying meaning that led you to select that particular quotation in the first place. ...it is important that the reader of the written word can ‘hear’ the intended meaning in the speech” (Thorne, 2020, pp. 4-5).

Although barely noticeable in conversation, the presence of filler phrases and repeated words in the text could be distracting and sometimes create impressions, like hesitancy, that were not accurate to the original conversation (Lapadat, 2000). By making the transcripts less exacting, they seemed to be more accurate.

Interview analysis

I began the interview analysis process by reviewing transcripts and identifying key emerging themes. Originally, I planned to analyse the transcripts using a cross-transcript thematic approach, one that drew on experiences, perspectives, and quotes across interviews. However, in the process of writing the initial chapters, I felt important context and meaning were being lost; interview quotes felt disconnected from the story each participant told (Richards, 2015). I chose to pivot to a thematic narrative approach using a multiple case study design (Riessman, 2008). Instead of drawing analysis and theory by coding *across* interview transcripts, I shifted focus to patterns and meanings *within* each transcript. Based on a set of chapter themes, in each chapter I chose to study several individual experiences

in-depth with the aim of gaining greater understanding of the complexities, subtleties, and context of what they had been through, as well as how their experiences related to other participants and wider literature on the topic (Stake, 2006).

Using a multiple-case-study design, I was able to interpret patterns of experience that occurred for the individual within the specific TBS they had attended in the context of the time period in which they had attended. For each substantive chapter, I conducted a literature review for the topic theme, and I compared this with the case study interview transcripts (Yin, 2014). From this, I identified points where the case studies demonstrated useful examples of pre-existing theory and knowledge. I also considered points where I felt the participant's experiences were not adequately described or theorised by pre-existing literature. I created new terms, typologies, and theoretical developments. For example, in the chapter on seclusion and restraint, I describe forms of seclusion that relate to being prevented from communication whilst remaining in the physical presence of other people ('social seclusion'). Case study participants were invited to review drafts of the case study material and provide feedback.

Coding transcripts

From the interview transcripts I conducted a thematic analysis to identify and report patterns in the data (Vaismoradi et al., 2013). Whilst I have included analysis on the ways in which we construct narratives, I have focused "primary attention on 'what' is said, rather than 'why', 'to whom', or 'for what purposes'" (Riessman, 2008, pp. 53-54). I began by coding themes expressed across interviews, such as "abuse from staff" and "long-term impacts" (Zapata-Sepúlveda et al., 2012; Silverman, 2006; Glaser & Strauss, 2017). I read transcripts and coded each time a participant mentioned an experience or perspective relevant to the theme (Saldaña, 2015). For example, I would read through transcripts and highlight and code any discussion of instances of staff-perpetrated abuse, as well as subcategories for types of abuse such as physical abuse and sexual abuse. From this I created the thesis structure and chose key themes for chapter topics. Once the chapter themes were chosen, I selected case studies and analysed the narrative within each transcript. For each case study, I focused analysis on who the participant was, what the TBS they attended was like, what they experienced inside TBS, the ways they coped with and resisted institutional control, the long-term impacts, and how these 'fit together' in how participants described their lives. I read and re-read each interview dozens of times, coding and making notes in qualitative analysis software NVivo as well as highlighting transcripts directly in Word (Silverman, 2006; Doucet & Mauthner, 2008).

Chapter themes

There were over a dozen themes I would have liked to have focused analysis on for the substantive chapters. However, to give sufficient time and space to each theme, I was only able to choose five themes for interview analysis. Although I had begun chapters on other themes, such as forcible transportation and wilderness therapy, I decided to prioritise topics not explored in-depth elsewhere in troubled teen industry literature. The topics I decided to address in-depth were LGBTQ+ 'conversion therapy', seclusion and restraint, institutional child sexual abuse, as well as a broader theme of epistemic injustice. As an activist-scholar, I was in a relatively unique position to have data to write about these issues and, hopefully, use the research to help raise awareness about them. However, there are many more

themes I would like to address in the future, including ‘attack therapy’ and peer surveillance in therapeutic boarding schools.

Case study selection

Once I had decided on the chapter topics, I used a theoretical sampling “careful case selection” approach (Eisenhardt, 2021, p. 149). I chose case studies based on which interview transcripts I believed could most effectively provide illustrative examples and contribute to the theoretical discussion of the topic. As a multiple-case-study design, part of the selection process for each topic was identifying the cases with the most useful commonalities and contrasts (Yin, 2014; Tight, 2017). For example, I chose two case studies for the chapter on ‘conversion therapy’ (CT): both participants are LGBTQ+ and self-described experiences of conversion therapy, an important similarity, but they also had critically contrasting elements, with one having experienced more overt forms of CT than the other, and one person is a gay cisgender man and the other a queer, non-binary person. Therefore, the case studies were selected purposefully for theory development (Flyvbjerg, 2010; Siggelkow, 2007).

I did not have sufficient space to include case studies of each participant I interviewed. The case studies included in this thesis were not chosen because I thought they were more important or interesting than others. Case studies were chosen due to several factors, including the depth in which an interview explored the theme of a chapter topic. I decided to use different case studies for each chapter theme, and some interviews were not included in one chapter because I hoped to discuss their case study for another topic. For example, I have written part of a chapter on forcible transportation, which includes three interviewees as case studies, and therefore these participants were not included in this thesis- not because their interviews were any less useful or relevant for the thesis, but because I felt the interviews were important for a topic I would like to explore in the future and hope to publish post-thesis. Although not every participant was featured as a case study, quotes from all interviews were included in the chapters on institutional child sexual abuse and the conclusion. Quotes and data from all participants were included in the questionnaire chapter. Therefore, every participant is directly featured in the thesis in some form. Each interview and questionnaire response is deeply valuable to me and has informed my analysis throughout my research. My inability to include all interviewees as a case study reflects that participants spoke of many important topics with such depth and candour that even a doctoral thesis was not large enough to cover it all.

Anonymity and case studies

One of the limitations of the case study approach is the difficulty of ensuring participant anonymity (Robson, 2016). There is a complex interplay in preserving the rich detail and contextual insight offered by case study design and the potential of participants to be identifiable (Gerring, 2004; Tight, 2017). I created pseudonyms for the participants and obscured potentially identifiable details. I removed the names of the TBS they attended, removed specific dates, and described locations in broad geographical terms. Issues of anonymity were also addressed in the participant feedback stage, which is described next. The risk of participants being identifiable is a central reason why I chose, for one chapter, not to use a case study approach. In the chapter on institutional child sexual abuse, I

returned to the original cross-transcript thematic approach. I felt the topic is so sensitive that the most ethical approach was to add additional protections to confidentiality.

Case study feedback

To enhance the accuracy of case studies and theoretical analysis, I invited each of the case study participants to provide feedback about their case studies (Slettebo, 2021). I sent participants an email to say I had created a case study based on their interview and the topic theme the chapter was included under (see Appendix 5). I offered to send them a draft of the case study and invited them to provide feedback. I explained that this was voluntary and that they did not have to engage in this stage of research. I specified a timeframe for them to respond but clarified that this was negotiable depending on the needs of the participant. Once a participant expressed that they wanted to see the case study, I sent this to them in an email. I did not want to overload participants with too much information, so I chose to send them extracts that related specifically to their experiences instead the entire chapter draft. Most participants took longer than I had planned to return their feedback, but others responded immediately. For three participants, I spoke with them over Zoom to discuss their case studies. All but one participant engaged in this stage of research.

The purpose of seeking case study participant feedback was to improve the research quality and involve participants in the work being produced about them (Birt et al., 2016; Tight, 2017). Firstly, this process allowed me to check for the accuracy of the case studies, and minor adjustments were made to reflect participants' clarifications. It also served as an opportunity for participants to request information they did not want to have shared be removed. The process further enhanced theoretical developments, as many participants added valuable information for analysis, and this sometimes helped clarify the interpretive conclusions made. Lastly, I hoped that the involvement process would improve participants' research experience by sharing some of the interpretive power with them (Slettebo, 2021). However, I recognise this was not a co-production process, as I still crafted the narrative and made final editing decisions (Sitzia, 2003).

One of the main challenges for this approach was concern that reading material about traumatic aspects of their past might be triggering or overwhelming for participants (Edelman, 2023). I tried to accommodate this concern by providing trigger warnings, encouraging participants to consider where and when they would read it, and reassuring them that they did not have to read it or provide feedback if it felt too difficult. The request for feedback was also complicated by the passage of time (Armstrong et al., 2022). For the first three case study participants I approached for feedback, the feedback process took place in 2019 for a journal article I wrote (published in 2020). The other case study participants were approached in 2022 and 2023, several years after their interviews. Most of the participants, however, expressed that they appreciated the opportunity to be further involved in the process. Several described reading their case study was difficult but also a powerful and validating experience (Hagens et al., 2009). At least for some, the feedback process helped to validate the research, and the research helped participants to feel validated.

Conclusion

The mixed methods multi-stage approach allowed for rich and dynamic engagement with the research. The questionnaire in the first stage collected data from a wide breadth of participants but lacked depth (Bryman, 2015). Interviews conducted in the second stage produced in-depth insight into former students'/survivors' experiences of TBS. This provided more detailed and nuanced understandings that the questionnaire could not capture, but fewer former students/survivors were represented. Analysis using a case study design in the final stage allowed for rich theoretical development and participant validation. However, a focus on individual cases can make it difficult to ascertain to what extent their experiences may be similar or different to the broader population (Yin, 2014). The research was conducted using non-randomised sampling, and therefore, the research cannot claim to be representative. Instead, the study has produced multiple forms of data on an under-researched topic and presents compelling insight into the experiences of former therapeutic boarding school students.

Chapter five: Former student's experiences of therapeutic boarding schools

Introduction

An online questionnaire was launched as the first research phase. The purpose of the questionnaire was, first, to understand who former therapeutic boarding school students are and their experiences. Second, the online questionnaire served as a sampling frame to identify former students interested in being interviewed about their programme experience (Thompson, 2011). In this chapter, I will provide an overview of the data from these questionnaires, including background information about participants' identities, the circumstances which led to their being sent to a TBS, basic information about the boarding school, and their overall experience of the school. Findings will be discussed alongside research limitations. The questionnaire results form a crucial contextual basis for the chapters that follow.

The questionnaire was organised under two overarching themes: demographic information about the participants, and participants' experiences of therapeutic boarding schools. The questionnaire asked open and closed questions, resulting in a mix of quantitative and qualitative data. Response analysis was undertaken from various approaches, including qualitative thematic analysis and quantitative descriptive statistics. A small number of responses were edited to remove potentially identifiable information. As discussed in the research methods chapter, the questionnaire was disseminated largely through social media and word of mouth. Therefore, the research does not represent all former therapeutic boarding school students. However, given the lack of publicly available information about this under-researched population, the resulting questionnaire responses created an important and unique dataset.

Questionnaire summary

The questionnaire was completed by over 100 participants who had attended more than 40 different therapeutic boarding schools. The participants were predominantly white, comprising around 80% of the respondents. Half were from high-income families, and around 40% were from medium-income backgrounds. More women than men completed the questionnaire, and just under ten per cent of participants were non-binary. Half of the participants identified as LGBTQ+. Participants had attended therapeutic boarding schools over several decades, ranging from the 1970s to the 2010s, with most having been students in the 2000s. The schools attended were located in 18 different states, with Utah being the state with the largest number. Around a quarter of the TBS were described as LDS-Mormon affiliated, and half were described as non-religious. Participants from high-income families were more likely to stay in TBS for longer periods than medium-income students, usually for one to two years. Over 80% of participants reported their overall therapeutic boarding school experience was 'very negative' or 'negative'.

Former therapeutic boarding school students believed they had been sent to the programmes for various reasons, these included mental health difficulties, problems in the

family, drug and alcohol use, having attempted suicide or having thoughts about suicide, self-harm, breaking the law, and problems at school. Several participants discussed that their parents perceived them to be “promiscuous”, and some described that being LGBTQ+ was related to why their parents sent them away. Several participants discussed having experienced abuse within and outside of the family, including child sexual abuse. For some individuals, the parents who sent them away were the same people who had been abusing them. Many participants had experienced trauma in their childhood and youth.

Participants' experiences of the troubled teen industry

These questions asked participants the name of the school they attended, what state the school was in, during what decade they attended the school, how long they were there, and if the school was religious. Throughout the chapter, all participant quotes reflect the original spelling and grammar, this includes misspellings and American spelling.

Overall therapeutic boarding school experience

Participants were asked about their overall experience of therapeutic boarding schools (“Was your experience of therapeutic boarding schools generally positive, negative or somewhere in between?”). Responses were restricted to multiple choice answers, with an ‘other’ option that allowed for participants to write-in their own answers. 113 questionnaire participants answered the question. Preliminary analysis showed that 90% of multiple-choice answers reported a “negative” or “very negative” overall experience. Once the questionnaire had closed and analysis of write-in ‘other’ responses included, this percentage decreased to 80%.

Most participants described their experiences as “very negative” (65%, n=74) or “somewhat negative” (12%, n=14). In the ‘other’ write-in section, three participants expressed their experience as beyond ‘very negative’. These participants described their experience of therapeutic boarding school as, “Fucking awful, degrading, oppressive, traumatizing”, “Destructive to my life in every way”, and “Worse than ‘very negative’ - the negative experience to which all others favourably compare.” Including these three comments, 80% (n=91) of participants described their experience of therapeutic boarding schools as negative or very negative. This contrasts sharply with positive experiences, only one participant considered their experience as “very positive”. Eight participants said their experience was “somewhat positive”. Together ‘positive’ and ‘somewhat positive’ experiences constituted 8% of the participant sample. Six participants described their experience as “neither positive or negative” but this number increased to 11 (9%) when including ‘other’ comments that described “some positive, some negative” or “somewhere in between”. The dramatic differences in responses are demonstrated in the bar graph below:

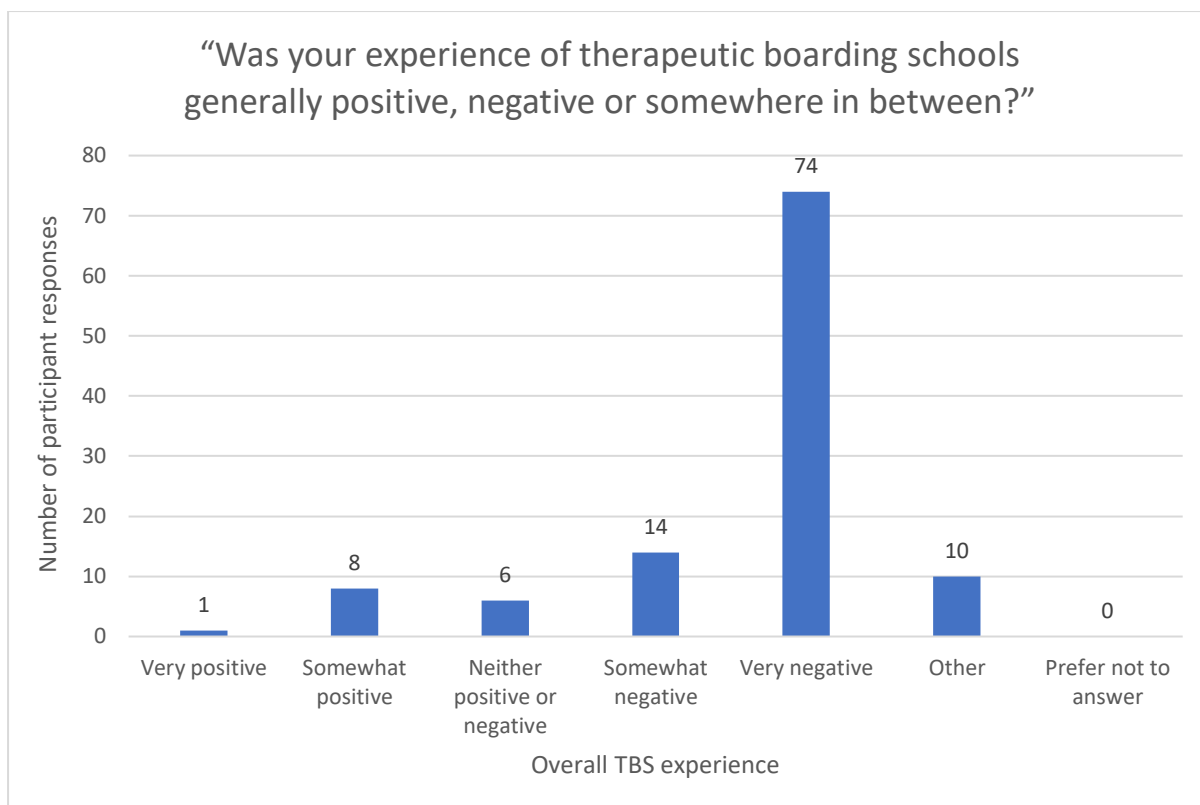


Figure 2- Bar chart on overall therapeutic boarding school experience

Programmes attended

Participants reported having attended over 40 different therapeutic boarding schools. Many had attended more than one therapeutic boarding school, with several having attended three or more. One programme had by far the largest number of participants ($n=23$) and represented around 15% of the overall participant sample, therefore this programme was overrepresented in the research. Also overrepresented was a school attended by nine participants. All other programmes were attended by five or fewer questionnaire respondents. The disproportionately high response rates of former students from some programmes appear to have been prompted by questionnaire participants sharing links with their peers, such as posting to programme survivors and alumni Facebook groups. Although some programmes were overrepresented, a spread of over forty programmes attended by just over 100 participants has created a unique dataset that includes a wide range of TBS.

Programmes attended had various names, some of which did not include the use of the words ‘school’ or ‘academy’. These include programmes that had branded themselves as a ‘residential treatment center’, ‘ranch’, ‘house’ or ‘manor’, ‘institute’, ‘challenge’, and ‘specialty program’. To protect participant confidentiality, I have chosen not to share the full name of any programmes. The distinction between what was a therapeutic boarding school and what was a related form of troubled teen industry programme, like wilderness therapy, was not always clear. This was especially the case for ‘residential treatment centers’ (RTC) and ‘therapeutic boarding schools’. For example, one programme that had been attended by multiple participants was described by some as a school and others as an RTC. I included the RTC responses if these met the specified inclusion criteria.

said it was not religious, but it was Mormon”, “there was no official religion, but the Mormon religion was pushed on us”, “it wasn’t supposed to, but it was primarily Mormon based and everybody that worked there was Mormon”, “supposedly it wasn’t, but everyone who worked there was mormon and they tried to take us to temple”. By contrast, two participants stated that LDS-Mormon staff ran their TBS but that this did *not* have a substantive impact on programme operations (i.e., “Morman based but we never engaged in religion” (original spelling)). Ten programmes were non-Mormon Christian affiliated, including non-denominational Christian, Catholic, Baptist Christian, and Evangelical Christian (Assembly of God). Regarding non-Christian religious programmes, there was a therapeutic boarding school which had a kosher kitchen to cater for Jewish students, but it was not considered to be Jewish in any other sense. Lastly, a couple of answers referred to the “Church of Synanon”, a drug rehabilitation therapeutic community turned religious cult that heavily influenced the therapeutic models used by the troubled teen industry (Szalavitz, 2007).

The decades in which participants attended therapeutic boarding schools

To better understand the periods in which participants had attended TBS, the questionnaire asked, “What year did you first attend the school?” Participants could respond using a drop-down menu to select a decade ranging from the 1960s to the 2010s. Most participants attended therapeutic boarding schools between 2000 and 2009 (58%, n=69). Around a quarter of participants attended in the 1990s (23%, n=27), and 15% attended in the 2010s (n=18). Three participants had attended programmes in the 1980s or the 1970s. Note the question asked when people *began* attending the programmes and do not represent the entirety of their stay. For example, as was later clarified in interviews, some participants began attending TBS in the late 2000s but graduated or left the programmes in the early 2010s. It is also important to note that questionnaires were primarily completed in the year 2018 and participation was restricted to adults who were no longer attending programmes. Therefore the lower number of participants who attended in the 2010s, as compared to the 2000s, would be expected as we had not reached the end of the decade. This was an unavoidable sampling bias. For this reason and others, the results should *not* be used as an indicator of a downward trend in therapeutic boarding school attendance.

Length of stay in therapeutic boarding schools

Participants were asked to approximate how long they were in a therapeutic boarding school (“Approximately how long did you attend the school for?”). Responses were gathered in a multiple-choice format. If participants had attended more than one therapeutic boarding school, they had been advised to refer to the programme they were in for the longest duration. This means for participants who moved between several programmes, the shorter stays were not represented in these results. Therefore, these findings do not reflect an overall average in length of stay, instead, they reflect the longest length of stay of each participant. Most participants had attended TBS for one (28%, n=33) to two (38%, n=44) years. Around a fourth of participants attended a programme for less than a year (24%, n=28). Eleven participants attended a TBS for three years (9%). No participant had attended a therapeutic boarding school for four or more years. The findings are demonstrated in the bar graph below:

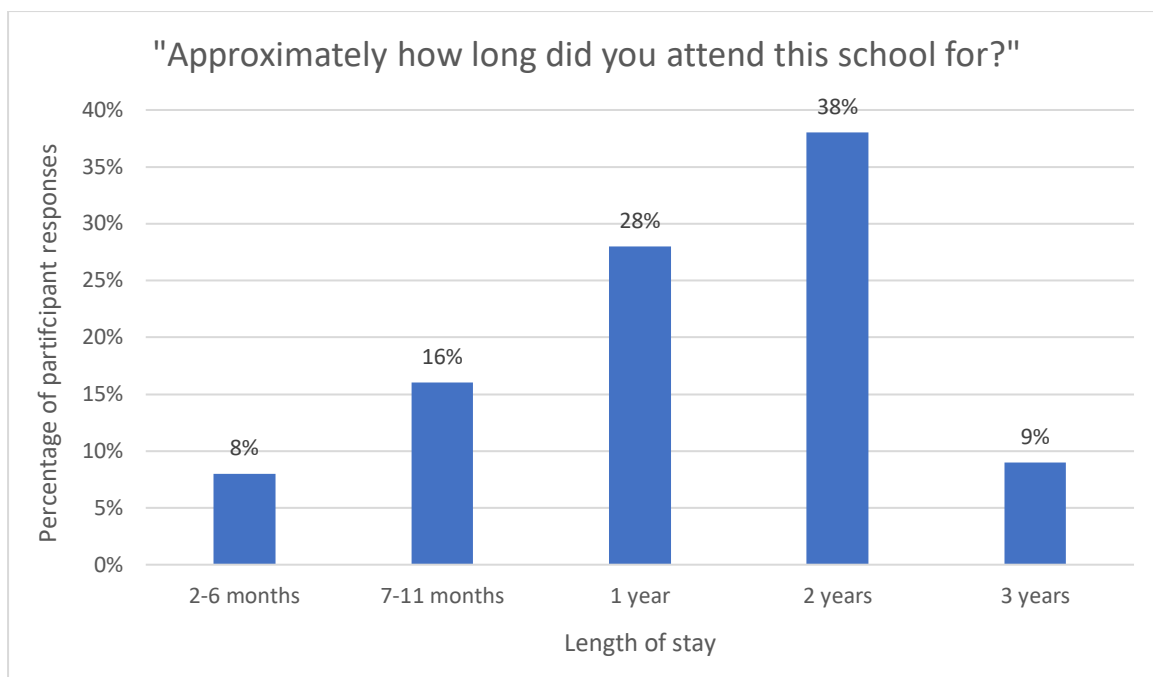


Figure 4- Bar chart on length of stay in therapeutic boarding schools

Participant demographics

These questions focused on the participants' backgrounds and identities. Question topics included participants' gender, sexual orientation, disability, family income level, and the current age of participants (at the time of questionnaire completion). Additionally, there was an open-ended question relating to participants' self-described race and ethnicity.

Gender

Respondents were asked two questions regarding gender. The first asked, "What is your gender?" and had the following response options: 'Male', 'Female', 'Non-binary (someone who is not 'male' or 'female' may identify as non-binary)', 'Questioning/ not sure', 'Other _____', 'Prefer not to answer'. The second question asked, "Do you identify as transgender or non-binary?" with response options of 'Yes', 'No', 'Questioning/ not sure', 'Other _____', 'Prefer not to answer'. The questions were in multiple-choice format with the option to write in a response under the 'other' option. Instead of limiting demographic information to a singular category of gender identity, a two-step approach to questions about gender helps address problems of trans erasure in research (i.e., limiting answers to 'woman', 'man', or 'transgender' is problematic because people can be both a woman and transgender) (Bauer et al., 2017). I asked questions regarding people's self-identified gender and not their 'assigned sex at birth' because I felt this information was less invasive for participants and more relevant to my research. However, there are inherent problems to pre-set gender category options; how we conceptualise gender, how we perceive our gender, how we describe this and to whom are deeply complex. While open-ended question responses would have allowed more space for complexity, this would have imposed limitations for data analysis (Ryan & Golden, 2006).

The questionnaire was completed by more women than men and non-binary people, with women constituting 67% (n=79) of the sample, men 23% (n=27), and non-binary people 8%

(n=9). Under the 'other' option, several people identified as intersex or genderfluid. In the follow up question, ten participants replied 'yes' to the question, "Do you identify as transgender or non-binary?" constituting 9% of the total sample. Of those who replied yes, almost all had identified as non-binary. Only one participant identified as a trans woman, and none as a transman. It is unclear why trans women and transmen were less likely to have completed the questionnaire and/or if they were less likely to identify themselves in these terms on the questionnaire.

Sexual orientation

Following the questions about gender identity, participants were asked to describe their sexual orientation ("What is your sexual orientation?"). Similar to the questions on gender, a multiple-choice response option was provided. Half of the participants identified as heterosexual/straight 50% (n=59), and half as LGBTQ+ (including 'other' and 'questioning'). Nearly a quarter of participants (n=28) identified as bisexual, and 11% (n=13) as queer. Seven participants described themselves as a lesbian/gay woman, and three as a gay man. Several people selected the response option 'questioning/not sure' or 'other'. Self-description under 'other' included "demisexual" and "pan" (pansexual), both of these identities signify attraction to multiple genders/beyond gender. For some participants, their gender or sexuality was connected to why they were sent away, and others did not indicate this was a significant factor in their experience (the reasons why participants were sent to a TBS will be discussed in more detail later in the chapter).

Research suggests that around 7% of the adult US population identifies as LGBT, but this more than doubles to around 20% of Gen Z Americans (Jones, 2022). Even when taking into account the age demographics of the sample, LGBTQ+ people are represented at a substantially higher rate than in the general population. The reasons for this are numerous but include the disproportionate pathologisation of LGBTQ+ people (including trans, non-binary, and bisexual youth specifically), as well as a sampling bias of who the questionnaire was likely to reach (Ross & Costa, 2022; Brown, 2017). One participant's response also highlighted the complexities of researching gender and sexuality in a population that may have been subject to conversion therapy, the participant felt unable to self-identify, "[I'm] not sure because I was put through conversion therapy at a time when I was confused. So totally unsure unaware and scared to explore."

Disability

Participants were asked if they identified as disabled ("Do you consider yourself to be disabled and/or D/deaf?"). To answer this question, participants could select from a list of generic disability categories. This was in a checkbox format so that participants with multiple disabilities could select multiple categories. Analysis of response rates was more complex than I had anticipated, as results reflected how many times each disability (or no disability) was selected and not how many participants identified as having one or more disabilities. On reflection, the question would have benefited from being two-stage asking first if the participant identified as disabled, and second with a specification of which disabilities. Further, I would not list the same categories today as I included in the 2018 questionnaire (see Appendix). I had prioritised questionnaire brevity and simplicity, but this compromised the quality of the research output on disability data. However, the responses still provide useful information about participant experience and identity.

‘Mental health difficulties or experiences of mental distress’ was the most common response selected, around 66% (n=78) of the sample identified with this category. This was followed by 43% (n=51) of participants who did not consider themselves to be disabled or D/deaf. Learning disabilities were common, a quarter (25%, n=30) of participants identified as having a specific learning disability. Chronic illnesses were also relatively common, with 15 people having selected this category, representing 13% of the participants. In addition to this, eleven people identified as neurodiverse/neurodivergent and five people identified as autistic. Smaller numbers of participants identified as having a physical disability or physical impairment, as D/deaf or as having a hearing impairment, and/or as blind or as having a visual impairment. Thirteen participants identified as having a disability, impairment, health condition, or learning difference that was not listed. One participant selected each disability category, and many identified with multiple categories of disability, meaning the sample included participants with a range of disabilities and/or people who were D/deaf.

Of note, many participants identified themselves as having mental health difficulties and did not consider themselves to be disabled. To a lesser extent, this was also evident with categories other than mental health. For example, one participant selected that they had ‘no disability’ but also that they had a ‘learning disability’. People considered disabled under medical or state definitions of disability may not consider disability to be part of their identity (Watson, 2002). Furthermore, the inclusion of mental distress as a psychosocial form of disability has been contentious (Rashed, 2019). Disability identity and terminology also vary across cultures, including between the USA and the UK; the US lexicon typically uses person-first language (“person with disabilities”), whereas identity-first language (“disabled person”) is generally preferred in the UK (Best et al., 2022). On reflection, the wording of the question I posed reflected the UK identity-first language (“Do you consider yourself disabled?” instead of “Do you consider yourself to be a person with disabilities?”). However, the language is always shifting and many in the USA prefer identity-first language, so there is no clear ‘best’ way to phrase the question.

Importantly, these answers reflect how participants perceived their disabilities (or lack thereof) as adults at the time of questionnaire completion. Many participants have described elsewhere in the questionnaire and interviews that their disabilities had not been identified or diagnosed when they were teenagers. For example, multiple participants were diagnosed as autistic or as having ADHD in adulthood. Moreover, being in the troubled teen industry was a disabling experience for some participants. Several described having developed an eating disorder when they were in a therapeutic boarding school, others developed physical health problems resulting from medical neglect, as well as other experiences of disablement. Alternatively, it is also possible that some former students who had mental health difficulties, disabilities, or health conditions as teenagers may no longer experience these. For example, one participant described changes in their mental health, “I don't have the anger management issues I had when I was a teenager anymore”. This was much less common. Therefore, it is important to understand the responses as a reflection of adult experiences and perspectives.

Regional locations of participants

The questionnaire asked participants to share their current state of residence (“If you are currently living in the USA, what state do you live in?”). I asked this question to gain demographic information about participants and to help identify potential areas to travel for in-person interviews at the next stage of data collection. Former students/survivors reported living in states across the USA, once again representing all major USA regions. Importantly, the vast majority did not live in the same state as where they went to TBS. Only six participants were living in the same state as the programme they attended as a teenager. Out of the 45 participants who went to a therapeutic boarding school in Utah, not one reported currently living there. Beyond the US, around 10% of participants lived in another country, including Canada and the UK.

Race, ethnicity, and defining whiteness

While all measures of identity have considerable limitations, asking questions regarding race and ethnicity proved to be especially difficult to frame. Quantitative measures found in many standard categorisations of race and ethnicity in the USA – such as the US Census 2020 which has only six race categories – seemed so crass, offensive even, that I felt these were incompatible with an intersectional feminist approach (N. Jones et al., 2021; US Census Bureau, 2022; United Nations, 2017). I decided to create an open-ended question for participants to self-define their race and ethnicity. This would ensure that race and ethnicity are included in the analysis but also allow participants to engage with the concepts on their own terms. The question on the questionnaire read, “How would you define your race and ethnic background?” The responses provided relatively unique insight into how participants perceived themselves, and to some extent, also how they perceived the concepts of race and ethnicity. This provided rich detail on individual participants’ ethnoracial heritage, information I could not have gained from asking participants to choose from identity checkbox categories.

The 111 varied responses to this question were predictably difficult to analyse. There was a clear majority of white people in the sample, but this also raised the question of defining whiteness, who counts as ‘white’? One complication was language differences between the USA and the UK. For example, many participants self-described as ‘Caucasian’, a label that is often used as synonymous with white in the US but is not typically used in the UK. Still, it was relatively straightforward to interpret the responses of those who listed themselves as simply white or Caucasian, or as both (i.e., “white/Caucasian”). Others described themselves as white or Caucasian and additionally listed countries/regions, such as “White/German”, “White, Eastern European”. The conceptualisation of whiteness was complicated further by responses that named only majority-white European countries and regions but did not specify if they were white/Caucasian. If I were to interpret these responses as ‘white’ would this reinforce the idea that it is only white people who are ‘really’ from the named country or geographic area (these places where white people rarely get asked, ‘Where are you *really* from?’). On the other hand, if I did not include these responses as ‘white’, would this function to obscure racial dynamics in the study? (Brodin, 1998)

With these limitations in mind, I decided to run a word frequency test to get a more concise idea of response trends. As per previous word frequency tests, I first used the word cloud

function to visualise which words were used most often. This generated the word cloud below:



Figure 5- World cloud on participant's race and ethnicity

I then used Qualtrics Text iQ function to tally how many times a word is used in responses. The test counted the word 'white' (n= 57) and 'Caucasian' (n =39) were the most frequently used words. Out of 111 question responses, 92 participants used either the word 'white' or 'Caucasian', or both words, to describe their race and ethnicity. Word frequency tests only analyse individual words and not sentences or phrases, meaning word frequency counts lack important context. People of mixed ethnoracial heritage who described themselves as white or Caucasian *and* another race or ethnicity are represented in this number (i.e., a participant who self-described as "white & Native American" would be counted as 'white' and as 'Native American' in word frequency tests). Additionally, one person used the word "white" to describe that they were adopted by a white family. Therefore, it would not be accurate to assume that all 92 participants who used the words 'white' or 'Caucasian' were white people, even if this may have been true of the majority.

A small number of participants identified as Hispanic or Latino, Asian, Native American, Arabic, and as mixed race or biracial more broadly. Notably absent, however, were any participants who identified as Black or African American, including people of mixed race. Nearly 15% of the US population identifies as Black, African American, or as mixed Black/African American (N. Jones et al., 2021). Within the minimal amount of research that currently exists on the troubled teen industry, this stark racial disparity is not unique to my study. In Marcus Chatfield's 2018 study of adults who had been in the troubled teen industry, of the 223 people he surveyed, 89% of participants identified as white, and no one identified as Black or African American (Chatfield, 2018). Similarly, there was only one questionnaire participant out of 34 who identified as mixed Black/African American in Heather Mooney's study on former students of one therapeutic boarding school (Mooney, 2022)⁴. However, one study based in an inner city "public, chartered, strict discipline academy" had a majority Black/African American population (Somers et al., 2021, p. 121). While it is arguable that these programmes are not akin, there is cause for white researchers to consider how we may inadvertently replicate a racially biased conceptualisation of what is and is not a part of the 'troubled teen industry' and have found this definition to be self-fulfilling in whom we reach through 'word of mouth'.

⁴ To my knowledge, we were unaware of each other's questionnaires at the time of dissemination and our research projects were not designed in relation to each other's work.

Family income level

Given the financial implications of private-pay TBS, collecting data on participants' economic backgrounds was essential. My original intention was to include data on participants' socioeconomic class. There is no straightforward means to measure social class as its meaning and signifiers change over time and often require attention to context and identity. Quantitative assessments of social class may include income level, education level, occupational prestige, family size/relationship, and access to resources (American Psychological Association, 2015). This data would be complex to gather and analyse. Originally, I opted for a subjective measure of class based on self-identity, asking, "How would you describe your family's social class at the time you entered the TBS?" However, social class as an identity also comes with limitations. In the USA, concepts such as 'working class' are often associated with Southern or Midwestern industrial workers and farm workers, but not, for example, low-income retail or white-collar workers (Bennett & Kochhar, 2020). Further, some Americans contend social class does not exist at all (Kochhar, 2018).

I chose to change focus from social class to family income level. By being more specific in my data collection, I felt this would bring clarity to what I was measuring. A class-only analysis could obscure data on actual income levels, and family income is essential to understanding the ability to afford therapeutic boarding school fees. For example, people with the cultural capital of the middle class may work in low-paying jobs. I changed the question to ask about income brackets, "At the time you were admitted to the school, what was your family's income?" For this question, the participant could select one of the following options from a list: 'High income', 'Medium income', 'Low income', 'No income/ only income was government welfare provisions', 'Other _____', 'Prefer not to say'. This income-only analysis has meant potentially useful information on the family's cultural and educational background is lacking. It should also be noted that participants may not have been fully aware of their parents' incomes, and I did not define income brackets according to annual salaries, in part because inflation over the decades would have complicated this measurement. Therefore, the responses record each participant's perception of their family income level.

Half of the participants considered their families as high-income earners at the time they were admitted into therapeutic boarding school (n=56). Over 40% of participants (n=45) believed that their family was medium-income at the time of admission. Only three participants described their families as low-income. No participant indicated that, at the time of admission, their family were on no income or lived primarily on welfare provisions. Five people chose 'other' and described their families' financial circumstances in more detail. These included being unsure of what parents' incomes were at the time ("Not sure is low or medium", "my parents did not share the details of their income with me"). Others used the opportunity to explain how their TBS tuition was paid, explaining that the costs were covered by the state, or fees were paid with assistance from relatives or money loaned from banks.

Correlation between family income and length of stay in TBS

The relatively small number of participants posed several difficulties and limitations for establishing correlations between variables, such as how gender may be a factor in former

students'/survivors' overall TBS experience. For most question responses, performing multivariate analysis was not possible because answers were heavily skewed. For example, I could not perform statistically useful tests on the overall experience of former students, as the number of participants who had a positive experience was so small that the demographic backgrounds of 'positive' participants are more likely to reflect individual differences rather than a broader pattern. Consequentially, I was only able to test a small number of variables with sufficiently spread response types. Of the small set of variables I was able to test (family income, sexual orientation, gender, length of stay, decade of attendance), only one correlation was significant at a 95% confidence interval: family income and length of stay in a TBS. The analysis was performed using Qualtrics' advanced data analysis crosstabulations function and chi-square tests.

Former students from high-income families were significantly more likely than their medium-income peers to have stayed in a TBS for three years. They were also more likely to have attended TBS for two years, as compared to their medium-income counterparts. I was not able to test for a correlation in data from participants from low-income backgrounds due to insufficient participant numbers. The bar chart below provides insight into the distribution of family income levels alongside the participant's longest period of residence in a therapeutic boarding. The numbers represent participant response counts:

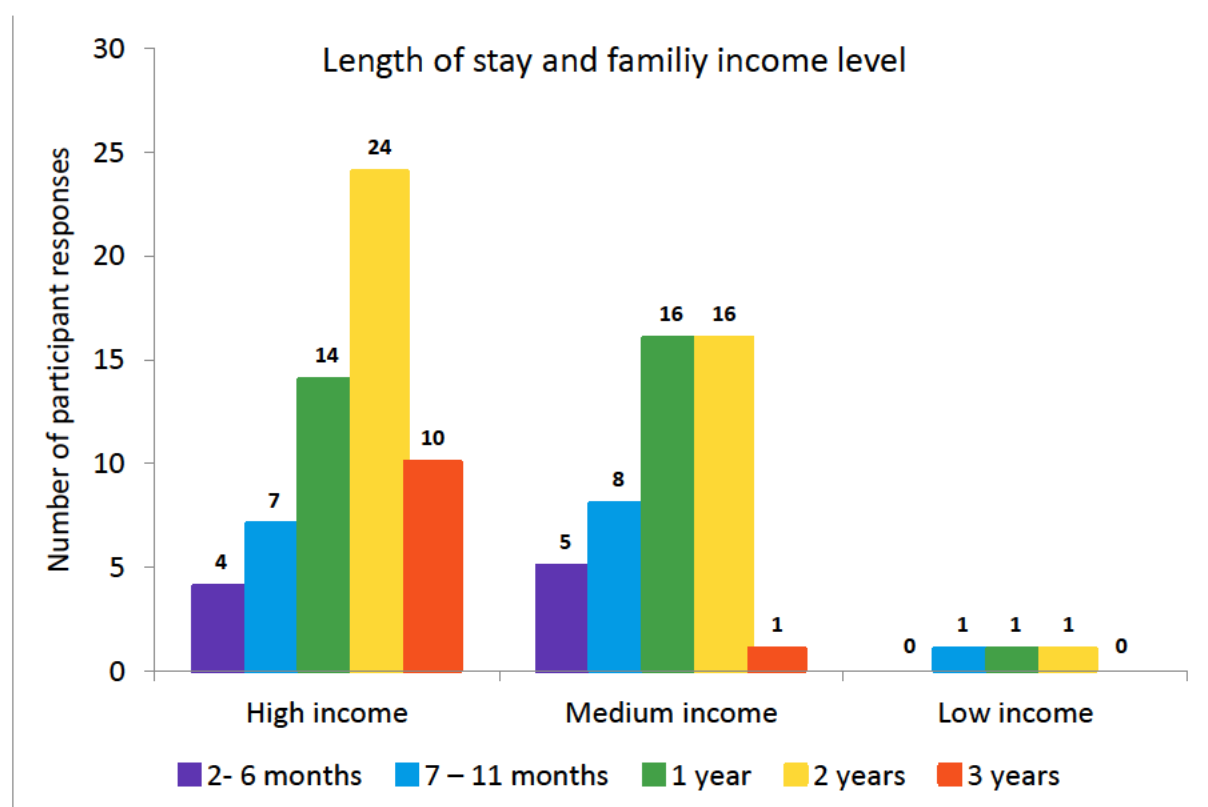


Figure 6- Bar chart on family income and length of stay in therapeutic boarding schools

This suggests that former students'/survivors' family incomes may be an important factor in how long students remain in therapeutic boarding schools. Former students from high-income families were more likely to stay in TBS for longer periods than medium-income students. There are several potential explanations for this, the most obvious being that high-income families can more readily afford to keep their children in very expensive

to establish exacting numerical or statistical outcomes, rather, the purpose was to organise responses and gain insight into prominent themes.

Family dynamics

I searched across the question responses for how many times participants referred to their families. I did this by searching for any mention of the following word search: 'family or parent or mother or father or mom or dad'. One or more of these words were present in nearly half of all entries. It seemed most of these were in reference to some form of problem, tension, or abuse within the family. This included statements where participants described their parents were overly controlling, having unreasonable expectations, or having unfairly pathologised them. Several participants described fights with their parents, refusing to abide by their parent's rules, and having been disrespectful towards parents. In one response, a participant explained, "My parents had a very authoritarian parenting style. When I became a teenager and started to test their limits, they reacted very harshly." Others stated their parents were overwhelmed and unable to cope, "I was refusing to listen, I self harmed, I was smoking pot, bad friends, I was considered bipolar and adhd and my mother couldnt handle me." Some former students felt their parents did not want to take care of them as teenagers, or that their parents wanted them out of sight, "My parents were not willing to take care of me."

Drug and alcohol use

Around a third of participants referred to alcohol or drugs as a reason why they went to a therapeutic boarding school. For most, drugs and alcohol were one issue among multiple, and substance use was described as part of a broader context of struggling with their mental health. One participant recalled, "I had alcohol issues at age 16-17, significant academic issues, severe depression and social withdrawal." Drug use was frequently discussed in tandem with problems at school, especially truancy, "Had trouble attending classes, pot smoking", "Polysubstance abuse, criminal activity, truancy". Only two participants listed substance use and no other issues, these stated simply, "I drank a little too much" and another, "smoked pot". For around half a dozen participants, marijuana was the only substance they described using at the time they were admitted to a therapeutic boarding school. Aside from marijuana, the type of drugs participants used was rarely specified.

Several respondents described that their use of drugs and alcohol was not substance abuse. These participants recollected their drug and alcohol use was normal teenage experimentation, had been used only in small amounts, or had been a way of self-medicating. One participant used quotations around the phrase 'drug problem', "I was a 'deviant' teenager with a 'drug problem'". Another response seemed to imply that they were sent to a programme for perceived drug use and not for actual drug use, that their parent became "convinced... I was on meth". One participant stated that they had mental health problems and behavioural issues, but it was their use of marijuana that staff were fixated on, "When i arrived the 'school' [they] really only focused on my cannabis use. They left me in solitary for days until i 'confessed' to my 'addiction'."

School, grades, and truancy

Many participants referred to problems at school, low grades, or skipping classes as a reason they were sent to a TBS. This was often related to broader issues such as drug use, behavioural problems, and struggles with their mental health. For example, one participant explained they were sent to a TBS because of “Depression, Anxiety, Trouble with academics”, and another due to their “Behavior/ Not going to school/ Not going home”. Others had faced expulsion from their previous high schools, “I was expelled from a regular boarding school”. Problems re-entering public high school systems following hospitalisation was also a reason for parents choosing to send them to a TBS. For example, one participant explained, “I had been hospitalized numerous times and was not able to reintegrate into public school. I was seeing a psychiatrist who recommended a therapeutic boarding school, presumably because my parents expressed fear that I would be a danger to myself”. Some were not doing their homework or had been getting low grades, “I stopped doing my homework, stopped attending high school, (because why bother if I'm going to fail all of my classes anyway?) and stayed at home all day, mostly playing video games.”

Suicide attempts and suicidal thoughts

Nearly twenty participants described having attempted suicide or thoughts of suicide as a reason they were sent to a TBS, meaning around 1 in 5 questionnaire participants described suicidality in their teenage years. For several participants, that they had attempted suicide was the only reason they gave for why they attended a therapeutic boarding school, “I had attempted suicide & my parents didn't know how to handle it”. Some participants recalled that, after having attempted suicide, their parents had been instructed or advised by a healthcare professional to place them in long-term residential treatment. In one example the participant's parents had been coerced by professionals to do so, “I attempted suicide after multiple hospitalizations for mental health issues. My parents were told to send me to a private treatment program or they would lose custody of me and I'd be committed to the state hospital.” Many respondents who had attempted suicide had a history of hospitalisation prior to entering the troubled teen industry. Around a third of those who mentioned suicide also had a history of self-harm. Some had attempted suicide multiple times. For example, one participant said they went to a therapeutic boarding school for “Attempting suicide multiple times, cutting, behavioral issues”. These experiences were commonly understood as a response to complex mental health problems and trauma.

Self-harm

Over a dozen participants described having self-harmed as a teenager. These participants often described mental health problems like depression, anxiety, and eating disorders. Many discussed self-harm as part of how they coped with trauma (Chandler & Simopoulou, 2020). For example, one participant reflected, “Looking back I can see the process of my PTSD and the way it affected me as a young child and progressed over the years. There were many reasons I was sent away... I was suicidal and cutting.” Self-harm appeared to have been a central reason for having been sent away for several participants. Many had contact with mental health professionals or a history of hospitalisation before they were sent to the TBS. Therapeutic boarding schools were sometimes recommended treatment for teenagers who had self-harmed, “They had sent me to many therapist and one said I needed to be in a lockdown facility due to self harm.” Suicide and/or self-harm appeared to be factors most often associated with hospitalisation. One student recalled having been sent to a TBS

because of, “Suicidal ideation, anxiety (general and social), depression and self-harm. I had previously been admitted to inpatient psychiatric hospital wards 3 times.” Although suicide and self-harm were often mentioned together, it is important to note that there were participants who described having self-harmed and who did *not* mention suicide and vice versa.

Gender and sexuality

Several participants reported that they were sent to TBS because their parents were uncomfortable with, or disapproved of, their being LGBTQ+. For some, the ‘coming out’ process appeared to be a trigger point for parents in the decision to send them to TBS. One participant described being sent away “For coming out to my parents and smoking weed”. Another participant reflected that their parents were “embarrassed” by their gender and sexuality, that they were sent away due to “My sexuality. For being transgendered. ...Embarrassing my parents. Being involved in a ‘negative subculture’... [they] wanted me gone.” Rejection of their gender and sexuality was experienced by participants even when parents did not overtly communicate gender and sexuality as a central ‘issue’. One of the participants recalled their parent's intentions were coated in language about ‘conflict’ and being ‘oppositional’, “My parents would say ‘family conflict’ or that I was oppositional, but they did not start feeling that way until I came out as gay”. Another participant had parents who sought TBS ‘treatment’ as “Reparative therapy.” It is also important to note that most LGBTQ+ people did *not* include their sexual orientation or gender identity as a reason they attended TBS.

Some participants described that they were seen as a sexually ‘promiscuous’ teenager and this was part of why they were sent away. Women and non-binary people were the only people who reported this. Their sexual activity was experienced by parents as an indication that they were ‘out of control’, “My mother was alarmed that, at 17, I'd had sex with my boyfriend... She felt I was out of control.” The participants recalled having been labelled ‘promiscuous’ as one of the multiple aspects that impacted their parent's decisions. For example, there were also problems with parents and difficulties at school, “Promiscuity, issues with parents, social problems in school”. One participant described having become sexually active at a ‘young age’, but it was not clear what age this referred to, “I was struggling in school with grades, disrespectful to parents, and beginning to become sexually active at a young age”. The number of respondents who specifically addressed sexual promiscuity in the questionnaire was low but included LGBTQ+ people as well as heterosexual/straight women.

Problems with the law

A relatively small number of participants described encounters with law enforcement as one of the main reasons they were sent to a TBS. Around half a dozen participants specified a history of legal issues when they were a teenager. Considering approximately a third of participants disclosed illegal drug and alcohol use, and some described criminalised behaviours such as theft, this number is relatively low. Two of the participants discussed going to a TBS in order to avoid criminal justice measures. For one participant, the criminalised behaviour was school truancy, they explained having been sent away due to “Depression, truancy that would have resulted in me being placed in the juvenile system if my parents hadn't send me”. Another had been arrested for drug possession on school

grounds, “I was arrested at school for pot. Had to get it expunged so was sent there. Had prior history of mental illness.” One participant reported they had been arrested at a protest, which concerned their parents, “In my teens, I got involved in political activity, which they did not like, and my parents sent me away after I was arrested at a protest”. Some did not specify the nature of their legal issues, “at the age 11 i started using drugs and was a wild child. i never went to school got in trouble with the law”. It is possible there are more participants who had faced legal issues but whom did not disclose this in the questionnaire, or did not see this as a central reason for having been sent to a TBS.

Experiences of abuse in childhood

Many respondents disclosed in their answers that they had experienced one or more forms of abuse in childhood. For most, this abuse was described as coming from within the home or perpetrated by a family member. Many of these former students felt they were pathologised and that how they coped was treated as ‘the problem’ instead of the abuse itself. One participant remembered their parents sent them to a therapeutic boarding school “thinking that me experimenting with marijuana and alcohol was the problem not them and the abuse I had and was living with at home”. Many of these young people were sent to a therapeutic boarding school by the same people (their parents) who had been abusing them. For example, one former student recalled, “My mother... interpreted my reactions to and defenses against her extensive emotional abuse as evidence that I was a defiant child.” A couple of participants described that they were made to go to a TBS to cover up abuse in the family. One participant who had been sexually abused by a family member said their “family was embarrassed and sided with abuser”. Another participant recalled their situation at the time, “I was suicidal and my parents wanted to make sure my grandparents didn't find out my dad molested me.”

There were also students who had experienced abuse from peers, or who did not disclose who had perpetrated the abuse. For example, one former student described they had made “suicide attempts following being raped by a classmate”. This participant was diagnosed as having Borderline Personality Disorder and was hospitalised, after which they were sent to a TBS. Another participant explained that as a teenager they were an “Emotionally disturbed teen who had been raped and turned to alcohol as a coping mechanism”. Another, “I was abused as child. Teachers, specialists and parents concluded that therapeutic boarding was best”. One former student/survivor described that as a child they had been subjected to human trafficking for the purposes of sexual abuse. These participants spoke of having to cope and survive profoundly traumatic circumstances. It is likely that sexual abuse, as well as abuse more broadly, was experienced by many more participants than those who chose to disclose this in the questionnaire.

Conclusion

The high levels of engagement with the questionnaire demonstrate that former ‘troubled teens’ are not a ‘hard to reach’ population; rather, they have been overlooked and under-researched. The questionnaire challenges the representation of TBS students as exclusive to the wealthy elite, as only half of the participants were from high-income families. In line with other TTI research, the majority of students were white, and few were from low-income backgrounds. The large majority of respondents did not live in the same state as

where they were sent to TBS, and this may be important to consider for those looking to provide support to former students/survivors. More comprehensive research is needed to gain insight into how representative the participant sample was of the former 'troubled teen' population. Future research would benefit from addressing potential sampling and definitional bias in relation to race and class.

There are many complex reasons behind why participants had been sent to TBS, including mental health problems, drug and alcohol use, and problems in the family. Some of these issues could be seen as in line with ordinary teenage development, such as 'talking back' and rebellion, experimentation with drugs, becoming sexually active, and exploring gender and sexual identity. However, many described profound struggles, including multiple suicide attempts and experiences of trauma and abuse; some had prior histories of hospitalisation. From minor rule transgression to having sex to self-harming to breaking the law, the former students were often considered to have been 'out of control'. The overwhelming majority had an overall negative or very negative experience of therapeutic boarding schools. This raises serious ethical questions about the industry and the welfare of young people who are sent to therapeutic boarding schools.

Analysis of the questionnaire responses provides the groundwork for understanding and contextualising the substantive chapters to follow. The questionnaires are a window into who former troubled teens are and what their experiences have been. The commonalities and variation in reported experiences have helped shape this research's major themes. The questionnaire also successfully served as a tool to invite a subsample of participants for follow-up interviews. From this, a subsample of interviewees has been presented as case studies. The remaining chapters have been informed by the questionnaire results but primarily draw on the qualitative accounts from interviews. The mixed methods approach has provided, through the questionnaire, a general overview of the experiences of former students/survivors, while the interviews and case studies provide a deeper engagement with the complexities and the hardships of what these participants have been through. In the following chapters the analytical focus shifts to specific topics: sanism and adultism, LGBTQ+ 'conversion therapy', seclusion and restraint, and institutional childhood sexual abuse.

Chapter six: Sanism, adultism, epistemic injustice and the ‘troubled teen’

Introduction

This chapter builds on the literature review and questionnaire responses chapters by describing and analysing how three former students/survivors experienced therapeutic boarding schools. By providing an analytical overview of sanism, adultism, and epistemic injustice, it forms a basis for the chapters to follow, which are on specific forms of abuse within the industry. The case studies were selected due to key similarities of when they attended the school and key contrasts, such as race and ethnicity, family income, gender, and sexual orientation. All three participants interviewed attended a therapeutic boarding school as teenagers in the 2000s. They were all sent to the schools by their parents without the participants’ full knowledge or consent. The case studies narrate negative experiences within the schools, which correspond to the questionnaire results - around 90% of respondents reported their overall experience in therapeutic boarding school was ‘negative’ or ‘very negative’.

The chapter seeks to ‘trouble’ how the ‘troubled teen’ is constructed and regulated through social processes of sanism, adultism and epistemic injustice. Epistemic injustice occurs when individuals and social groups have their credibility as knowers undermined or denied (Leblanc and Kinsella, 2016; Scrutton, 2017). Sanism refers to discrimination against and oppression of people with lived experience of mental distress, and adultism refers to the discrimination against and subjugation of children and young people (LeFrançois, 2020; Liegghio, 2020; Poole, 2012). Young and psychiatrised people in residential treatment facilities are situated as lacking the capacity to act in their best interests and, therefore, can be subject to institutional interventions without their consent. The case studies of three former students/survivors record harmful long-term consequences of therapeutic boarding schools. However, the schools’ strict structure and surveillance culture could not override students’ will and their ability to find means to resist. This chapter is an adapted version of the 2020 article *Troubling the ‘troubled teen’ industry: Adult reflections on youth experiences in therapeutic boarding schools* (Golightley, 2020).

Case studies

Jasmine

Jasmine identifies as a biracial Asian American bisexual woman. She was raised by wealthy Christian parents in a small town in the ‘Bible Belt’ of America. She described her early childhood as ‘privileged’ and ‘idyllic’. However, as she grew older, and became interested in heavy metal and goth subculture, she felt increasingly out of place in her predominantly conservative environment. Fights with her father became increasingly common, ‘sometimes he wouldn’t like my clothes, or I hadn’t done my homework or something, and it would just kind of escalate’. As the arguments became increasingly heated, her father would punch her, and she would hit back in self-defence. At around the age of 14, she started self-harming. The fighting with her father continued to escalate until one day Jasmine confronted her father with a knife, demanding that he stop hurting her. Following this,

Jasmine was briefly placed in a psychiatric hospital. From the hospital, she was taken to a wilderness programme and afterwards was sent directly to a therapeutic boarding school.

Lukas

Lukas is a Latino gay, cisgender man who was adopted as an infant into a white middle-class family in a town in the North East. Lukas was a creative and artistic young person, and he describes his teenage years as 'rebellious'. He had difficulty fitting in: 'I'm Latino and I'm also gay and I think that those things have made it challenging, just like a hundred percent sort of blending into the culture here because it's, I think, set up for rich white straight people'. When he was 14, he went through a self-described 'punk phase' and started using drugs, partying, skipping classes, and his grades were in decline. His substance use escalated to the point where his parents enrolled him in a drug rehabilitation programme. To try to improve the situation, he changed from the town's public school to a private boarding school that focused on the performing arts, but shortly afterwards Lukas relapsed. One early morning he was woken in his family home by two strangers, 'transporters' who took him to a wilderness programme. After finishing the wilderness programme, he was sent to a therapeutic boarding school.

Christina

Christina is a white heterosexual, cisgender woman who was raised in a low-income family in a large city in North East, United States. She says she has always been a friendly, bubbly person, 'a good person, you know, I just struggled more as a teenager'. By the time Christina was 16 years old, she used drugs, drank alcohol, and had stopped going to school. She often did not return to the family home, instead stayed with an older boyfriend. Her family often did not know where she was or if she was safe. 'My parents were looking for me and I was living at some guy's house, and I thought I was cool, and I wasn't going to school, and I thought I knew it all'. Christina's parents called the police and the whole neighbourhood was alerted that she was missing. Christina was eventually found at the boyfriend's home. Her parents handcuffed her to the staircase as they waited for 'transporters' to arrive. It was then that Christina was told that she was going to a boarding school.

Sanism, adultism and epistemic injustice

Young people become 'troubled' through a process of psychiatrisation, as their emotional health collides with the expectations of the sanist-adultist world. Jasmine believes a major reason she was sent to a therapeutic boarding school was because she broke her silence on sexual abuse within the family when she was placed in a psychiatric ward:

I reported sexual abuse by a relative to the psychiatrist . . . at the time, my family was . . . they were shocked and humiliated by my testimony. They urged me to recant what I'd said and admit that I made it up. They suggested the incident was part of hallucinations . . . not long after this, I was placed on Abilify, the anti-psychotic medication. I believe this event, along with consultations with the educational consultant, weighed heavily on my parents' decision to send me away.

The above quote exemplifies psychiatrisation of abuse victims/survivors that disrupt the social norms of family life by disclosing the abuse. Jasmine further described that she felt sent away to 'save face' and that the psychopharmaceuticals were used to placate her, what she described as a 'pharmaceutical lobotomy' (Burstow, 2015). She discussed that since her family had already been 'othered' due to being Asian in a wealthy, white-dominant Southern society, her family were very concerned with family appearances and 'fitting in' (Tam, 2014). Placing Jasmine in a therapeutic boarding school geographically distanced her from the family, hid her disclosure and preserved the family's precarious sense of cultural belonging.

As sanism and adultism converge, psychiatrised young people often do not have the power to determine what, if any, interventions would be best for their wellbeing. For those labelled 'troubled teens', many are 'transported' to treatment facilities without their knowledge or consent, as was the case for Lukas:

I was literally woken up and it was probably very, very early morning and these two men were just like in my room, you know, they're like 'get your stuff and let's go, we're going'. And I was just sort of like, 'what's happening?' And we got into this truck, which I remember had some sort of caging . . . that's really scary, you know . . . It was definitely a shocking thing . . . I remember being very angry just 'cause I felt, sort of, I felt betrayed. I felt . . . supremely disrespected . . . nobody asked me what I thought, and this is happening, and I don't like it.

Lukas speaks of the sense of anger, disrespect and betrayal he felt when he was taken into treatment, a decision made by adults without consulting him. Parents can authorise 'transporters' to gain temporary legal custody over their children, therefore 'transporters' can legally remove young people against their will (Robbins, 2014). Young people forced into treatment by 'transporters' are, by design, denied the right to informed consent.

Even when 'troubled teens' are permitted input into their treatment, if their perspective diverges from that of the adults, the young person's voice is often overridden. All three case study participants spoke of not being believed by school staff as well as parents because of the social stigma associated with being a psychiatrised young person. Staff would actively undermine the young person's account, telling their parents, as well as other students and staff, that their accounts were irrational, manipulative or false. Christina tried to tell her parents about the poor conditions of her school, but was not believed:

It was very confusing cause like I'm thinking 'why are my parents sending me here?', like this place is crazy . . . I don't know if they knew what was really going on or not . . . I would try to write to them and tell them some things . . . but, you know, staff would just tell them we were manipulating and who were they supposed to believe?

Christina outlines in the quote above how, once enrolled in a therapeutic boarding school, her objections to school's treatment were not taken seriously. In this way, adult healthcare professionals can become gatekeepers of what is deemed true and reasonable. This system-wide epistemic injustice results in psychiatrised youth being refused control over their own narratives.

Resistance and reclamation

Therapeutic boarding schools function as ‘total institutions’, students at these schools are grouped as ‘troubled teens’ and live under the singular administrative authority of the school, where they have limited contact with the outside world, are not routinely allowed to leave school property and students reside in such schools for periods lasting several weeks to several years (Chatfield, 2019; Goffman, 1968). Therapeutic boarding school life is constructed around strict schedules, extensive rules and the reward/ withholding of privileges. Therapeutic boarding schools are designed to resocialise, to create a social environment that alters the mindset and actions of individuals who live there. Yet, despite this stern institutional setting, young people find ways to resist.

Daily life in therapeutic boarding schools is devised into a set of rules, including if and who a student can talk to, what time a student wakes up and goes to sleep, what and when they can eat, as well as where and when they can enter various parts of the school campus. Students are constantly under surveillance by staff as well as fellow students, all of whom are required to report any breach of the rules. Rules and regulations can be so extensive that it may be difficult to avoid breaking them, especially as some rules can be arbitrary, inconsistently applied depending on interpersonal staff–student dynamics. In response, many students self-regulate their behaviour and conform out of fear of punishment (Scheff, 1984). Lukas discussed the rules and punishments he experienced in the therapeutic boarding school:

There was always [something] looming over you, all of these repercussions and punishments, and, you know, strict rules and . . . the consequences for everything. . . . Sleeping on a bed was privilege, one time [as a punishment] I was thrown into the hall on a mattress.

The excerpt above brings to the fore the chronic anxiety that Lukas experienced in the school, as he constantly feared punishment. When Lukas did break a rule, the punishment included tactics to publicly shame him, such as forcing him to sleep on a mattress in the hallway of his school. Strict rules and punishments would lead to many students deciding to ‘keep their head down’ and at least appear to be following the rules (Polvere, 2014).

Students found ways to subvert rules in ways that evaded detection. Therapeutic boarding schools create hierarchies of students, with ‘upper level’ students having more privileges than ‘lower level’ students. Students would be rewarded for good behaviour and following the rules by being progressed to higher privilege levels. Students would become competitive with each other, report fellow students’ rule breaking and accuse peers of wrongdoing to divert attention from themselves. However, students also formed bonds with each other and together would find institutional workarounds. The therapeutic boarding school Christina went to did not permit students to exchange contact information, so Christina and her friends decided to develop a secret code between them. This code conveyed the information they would need to stay in touch outside of school. Christina explained,

I still keep in contact with them [my friends from school], which is a huge no, no. We weren’t allowed to give each other phone numbers, addresses,

nothing of that sorts. So, we found ways around it. See, the program taught me how to be really sneaky . . .

Christina and her friends would write fake book chapter titles to signify street names and numbers so they could be in contact once outside the school. Students found ways to act creatively as a means of resistance to bypass institutional scrutiny (Mills, 2014).

When young people felt unable to break the rules due to fear, students learned to resist in mindset. Students would fake compliance as a means to subvert institutional expectations and expediate their release (Mills, 2014; Polvere, 2014). Jasmine described having ‘good behaviour, despite inward dissent’. Similarly, Christina recalled,

I didn’t work the program when I first got there because I’m like ‘what the heck is this?’ but then eventually you realise you’ve either got to fake it till you make it, you got to do something or you’re not getting out.

The former students learned how to resist the strict environment without detection. Students would tell therapists what they thought they wanted to hear, dress and act according to expectations, carry out chores and follow the rules to progress through the programme, all while maintaining a subversive mind-set.

At times, students would choose to overtly break school rules and endure the consequences. Christina recalled seeing two female students kiss each other in private and when the students were caught they were punished by having everyday privileges revoked. Jasmine recalled a fellow student who refused to conform to the gendered expectations of the school:

[The therapeutic boarding school staff] gave her feminine clothes to wear. She refused them and so they let, they finally like let it go and let her wear like neutral, gender neutral clothes, like t-shirts and sweatpants.

As the quote from Jasmine demonstrates, non-normative gender expressions were actively discouraged at her school (LeFrançois, 2013; McCormick et al., 2017). The schools remove markers of social identity, especially if this identity is seen as socially undesirable. This encourages students to adapt to the norms of institutional life and develop a new identity. However, the schools were not always successful in achieving this. As an openly gay student, Lukas was a target for homophobic bullying from staff, but this homophobia did not shift his self-identity. Students were able to find ways to resist in their external behaviour and by holding on to their internal sense of self.

All three former students remain in touch with other students they met at school – and some of these connections have turned into lifelong friendships. Many former students have reconnected through online school ‘survivor’ groups. In the groups, students bonded over the extreme circumstances they endured together. They support each other and also collectively engage in making fun of the institutions that they once feared. Christina felt that former students could understand her experiences in ways that those who had not been there never could. She described her boarding school friends as ‘like my soul sisters, one hundred percent, they’re my bestest friends’. Friendships and community helped former students to affirm each other’s experiences and craft collective narratives of what the

therapeutic boarding school experience was like. Some former student groups have organised public awareness campaigns, written news articles, filed joint action lawsuits against the schools and lobbied the government to enforce industry reform (WWASP Survivors, 2019). Community support and awareness raising has formed a powerful means of disrupting the industry-sanctioned 'troubled teen' narrative.

While former students found ways to resist and survive in the schools, there are aspects of their experience with which they still struggle. Jasmine, Lukas and Christina continue to show the effects of trauma from their time in therapeutic boarding schools. Among them, they reported chronic anxiety, ongoing nightmares about the schools, feelings of anger towards family members, struggling to make friends and trust people, and a need for ongoing counselling. Adjusting to life after leaving the schools was a long process for them academically, financially, socially and emotionally. Identifying the hardships they endured was an important part of their healing. Time and space away from the schools allowed them to redefine their experiences on their own terms. Years after leaving the therapeutic boarding schools, they have been in a process of reclaiming their stories (Costa et al., 2012). In interviews, the former students discussed wanting to participate in this research project as a way of getting stories like theirs known to the wider public.

Conclusion

Young people who have been psychiatrised and labelled as 'troubled teens' have socially transgressed sanist–adultist expectations of behaviour and emotionality. Epistemic injustice enacted on 'troubled teens' has troubling consequences for many young people who are placed in therapeutic boarding schools. Therapeutic boarding schools are facilities that are designed to control and minimise deviance among young people in their care. Former students recalled ways in which they resisted institutional constraints through faking compliance, subverting regulations and overt rule-breaking. Many former students have contacted each other and built communities where they can share their experiences. These former students should be the key determiners of how we speak about the experience of 'troubled teens' in therapeutic boarding schools.

Chapter seven: Conversion therapy

Introduction

Former students and industry survivors have reported physical, sexual, and emotional abuse from staff as well as neglectful living conditions (Fleck, 2021; Beattie, 2020; Mooney, 2021; National Disability Rights Network, 2021). Former students have described experiences of so-called 'conversion therapy' inside therapeutic boarding schools (Sugiuchi, 2020; Kingkade, 2018; Kappel, 2017; Friday, 2017). 'Conversion therapy' refers to a range of religious and pseudo-scientific practices that attempt to 're-orient' people who are perceived to be lesbian, gay, bisexual, transgender, queer, or questioning-- LGBTQ+ or thought to be 'at risk' of becoming LGBTQ+ (Mallory et al., 2019; Human Rights Campaign, 2021). 'Conversion therapy', also known as 'reparative therapy' or 'sexual orientation and gender identity and expression change efforts', aims to change an individual's thoughts, desires, and expressions to more closely align with conservative gender and sexual norms (Przeworski et al., 2021; The Trevor Project, 2021; Goodyear et al., 2022). These practices have included aversion therapy, hypnosis, prayer circles, medications, and talk therapies.

Background literature

Research into 'conversion therapy' remains limited, but the most common forms of 'conversion therapy' in the USA today appear to be psychotherapeutic and religious approaches (Rosik et al., 2021; Przeworski et al., 2021; Ryan et al., 2020). Psychotherapeutic approaches envision being LGBTQ+ as a form of psychological disturbance resulting from childhood trauma or attachment issues, which the practice attempts to 'resolve' through cognitive behavioural and/or talk therapy approaches (Carr & Spandler, 2019; Ryan et al., 2020; Pyne, 2014). Religious 'conversion therapy' approaches typically are underscored by the belief that being LGBTQ+ is 'unnatural', against the wishes of God, or sinful (Newman et al., 2018; Dehlin et al., 2015). Religious efforts to change sexual orientation include anti-LGBTQ+ religious education, as well as the use of exorcisms, prayer and other rituals (Substance Abuse and Mental Health Services Administration, 2015). Both psychotherapeutic and religious 'conversion therapy' approaches can include forcing a person to dress and act in ways that conform to conservative ideals of gender and sexuality (Przeworski et al., 2021; Ansara & Hegarty, 2012).

The practice of 'conversion therapy' has been widely condemned by most major health and social care associations in the United States (Human Rights Campaign, 2021). Evidence does not support that 'conversion therapy' can 'convert' a person from being LGBTQ+ into being heterosexual and cisgender - a cisgender person is someone who identifies with the gender they were assigned at birth, in other words, someone who is not transgender (Ansara & Hegarty, 2012; Substance Abuse and Mental Health Services Administration, 2015; Przeworski et al., 2021). Furthermore, there is significant evidence that 'conversion therapy' has harmful long-term impacts, including an increased risk of self-harm and thoughts of suicide as well as difficulty forming intimate relationships (Blosnich et al., 2020; Ryan et al., 2020). Researchers at the Williams Institute School of Law, UCLA, estimate that as many as

350,000 LGBTQ+ adults in the USA have been subjected to 'conversion therapy' as children and youth (Mallory et al., 2019, p. 1).

To date, there have been no independent research studies that have evaluated the extent of 'conversion therapy' practices in therapeutic boarding schools. Because of the lack of comprehensive data, it is not known the extent to which TBS have experienced conversion therapy. What we do know is that former therapeutic boarding school students have reported harrowing experiences of 'conversion therapy' as part of the institutional practice (Sugiuchi, 2020; Friday, 2017; Kimble, 2016; Branson-Potts, 2015). LGBTQ+ former students have been pathologised, bullied and sometimes punished for expressing themselves as LGBTQ+ individuals (Kingkade, 2018). In the absence of large-scale representative data, this article aims to bring to the fore in-depth narratives of two former therapeutic boarding school students who have experienced 'conversion therapy'. 'Conversion therapy' as a form of epistemic injustice and oppression will be discussed. The article highlights how young people inside therapeutic boarding schools can experience harmful anti-LGBTQ+ practices, which can have lasting negative impacts.

Defining Conversion Therapy

'Conversion ideology' is premised on the belief that all people are naturally capable of being or becoming heterosexual and cisgender (Csabs et al., 2020). The ideology constructs being cisgender and heterosexual as the only healthy and 'natural' way to be. Same-gender attraction and gender non-conformity are perceived as a product of developmental or spiritual disturbance. This has been referred to as a theory of 'sexual brokenness' (T. Jones et al., 2021, p. 3). Within conversion ideology, the 'brokenness' of same-gender attraction and gender non-conformity can and should, be changed through a series of conversion practices and the removal of LGBTQ+ social influences. If a person cannot become, or be 'restored' to, being heterosexual and cisgender, then the person should work towards maximum suppression of LGBTQ+ feelings, desires and expressions (Goodyear et al., 2022).

Sexual orientation, gender identity and expression change efforts (SOGIECE) are practices that pressure a person to change or suppress their sexual orientation, gender identity or gender expression to more closely align with cisgender and heterosexual norms (Kinitz et al., 2021; Salway, 2020). I use the word 'pressure' where other scholars have used 'attempt' to reflect that SOGIECE can be enacted with or without intentional effort and can be perpetuated knowingly or unknowingly. I use the term 'conversion therapy' to describe SOGIECE practices that occur within formal 'care' settings, such as TBS. There are forms of conversion therapy enacted on intersex people and asexual people, but this is beyond the scope of this article, as no interview participants disclosed either of these identities or backgrounds (Cuthbert, 2022; Ashley, 2021). This article will outline how LGBTQ+ conversion therapy can operate in overt and covert forms in TBS.

Method

For this chapter, I selected two case studies of LGBTQ+ participants who identified their experiences in therapeutic boarding school as a form of conversion therapy. The two cases present important comparisons and contrasts. The first case study participant attended

therapeutic boarding school in the 1990s, and the other two decades later, the former participant experienced more 'overt' forms of conversion therapy than the second. Both participants were white and from high-income family backgrounds, but one identified as a gay cisgender man and the other as queer and non-binary. The chapter provides vignettes that go into greater depth than other chapters because these were analysed as comparative cases. This chapter is an adapted version of the 2023 journal article *"I'm gay! I'm gay! I'm gay! I'm a homosexual!": Overt and covert conversion therapy practices in therapeutic boarding schools* (Golightley, 2023).

Case Study One – Overt Conversion Therapy

Jeremy is a white cisgender gay man who grew up in a conservative Christian, wealthy suburban town on the US West Coast. He attended a TBS in the 1990s. I have interpreted Jeremy's experience of TBS as overt conversion therapy. I define 'overt conversion therapy' as practices that openly aim to facilitate the change or suppression of a person's sexual orientation, gender identity or gender expression. These reflect practices that have been commonly associated with conversion therapy. The programme Jeremy attended utilised psychotherapeutic conversion therapy techniques that sought to uncover and resolve past traumas as a means to render him heterosexual. The programme openly sought to change his sexual orientation, and this is one of the main reasons Jeremy was sent to the TBS. Jeremy explained, 'my mother didn't want a gay son and the school promised to "cure" me.'

Jeremy reported that he was raised in a high-income family with an alcoholic mother and emotionally unavailable father. Jeremy had attended the local conservative Christian high school where he was frequently the target of bullying from his peers. He was sixteen years old, isolated, depressed and, as he described it, 'trying to figure out' his sexuality. His parents suspected he was gay and decided to send him to a TBS in the rural Southeast. Jeremy agreed to go to the TBS as, in his words, 'an opportunity to get away', but, he reflected, 'I don't think I really understood what that meant.'

At the TBS Jeremy was sent to, sex and sexuality were largely unacknowledged, including heterosexual desire. Even thinking about sex was against the rules. Jeremy recalled the rules as, 'no touching, no holding of hands, no sexual thoughts'. During the initial period of the programme Jeremy was not 'out' as gay. However, a few months in, staff found gay pornography on his laptop and Jeremy felt he had no choice but to 'come out'. Jeremy described:

They found the pornography on my laptop and of course, they were like, "why are you looking at gay porn?" And at that point, I just remember saying like "screw it", "I'm gay!" I came out and then I had to tell everyone in my therapeutic group what had happened... I marched into my dorm room and said, "Attention, everyone! Attention! I'm gay!" I began skipping around the entire school shouting, "I'm gay! I'm gay! I'm gay! I'm a homosexual!"

Jeremy had decided to publicly declare his sexual orientation to the entire school. He felt he had to get ahead of the rumours he suspected would swiftly circulate.

After publicly declaring that he was gay, Jeremy was put 'on restriction'. At Jeremy's TBS staff operated a 'privilege level' system where a student's perceived emotional progress and good behaviour were rewarded by level promotion, and perceived non-compliance resulted in demotion. 'Privileges' were not merely superfluous comforts, moving up privilege levels protected students from the most extreme living conditions and maltreatment. Demotion to the lowest level was a severe punishment. Jeremy was removed from the day-to-day life of the school and no longer allowed to communicate with his peers. He explained the conditions of being 'on restriction':

We [students 'on restriction'] were made to sit out in the cold or in extreme heat. There were times that we were shoved and beaten. Certainly, I think the being forced to haul [heavy objects], and do standing positions, your back to a wall, standing like you were on a chair for hours on end, being denied food on a regular basis, or minimal caloric intake, it is a torture amount of abuse.

Jeremy described students with the lowest privilege would be subject to deprivation, degradation and abuse. Furthermore, Jeremy believed that one of the staff's motivations for assigning him manual labour was to try to encourage him to be more 'masculine'.

Staff approached his sexual orientation as being the consequence of trauma. They assumed Jeremy had suffered sexual abuse in childhood that had 'turned' him gay, even asking Jeremy if his father had sexually abused him in childhood. He recalled:

They [staff] certainly viewed my homosexuality as something to be cured, as a behavioural issue. I remember my own counsellor asking me if my dad had molested me and if that had turned me gay. And I was like, "no, he did not!"

Staff at the programme Jeremy attended wanted to 'cure' him of being gay and sought to find instances of child abuse to explain what had supposedly 'turned' him gay. Jeremy believed that even when the staff eventually came to accept that they could not 'cure' him, 'they would have wanted me to be a gay man without sexuality', he told me. In other words, if Jeremy could not be made heterosexual, staff wanted him to suppress his sexuality and conform to heterosexual norms as much as possible.

After attending the TBS for nearly three years, Jeremy left the programme just before his nineteenth birthday. After the programme, Jeremy experienced anxiety attacks and had a heightened fear of homophobia. He described that he had post-traumatic stress related to the time he spent at the TBS. This impacted his ability to form romantic relationships and created anxieties around sexual intimacy. Jeremy saw a therapist for many years to work through his experiences. At the time of interview, he no longer had a relationship with his mother, who he never forgave for sending him to the school with the intent of 'curing' his sexual orientation. Jeremy said he now lives proudly as who he is, stating, 'my sexual orientation is well integrated into my identity.'

Case Study Two – Covert Conversion Therapy

Eli is a white, queer and non-binary person from the US Southwest who attended a TBS in the 2010s. They grew up in a middle-income family who had been generally supportive of their sexual orientation and gender identity. I have interpreted Eli's TBS experience as covert conversion therapy. I define 'covert conversion therapy' as practices that do not openly or explicitly attempt to change or suppress a person's sexual orientation, gender identity or gender expression, but where there is sustained pressure by persons in authority for such change or suppression and an underlying conversion ideology. The intentions of covert conversion therapy practitioners may be unclear to those being subjected to it, and practitioners could enact conversion practices unknowingly. The TBS Eli attended promoted itself as LGBTQ+ friendly. Nonetheless, the programme operated from a premise of conversion ideology that insidiously pressured Eli to change and suppress their sexual orientation, gender identity and expression.

Eli struggled with depression and anxiety from early childhood. They had difficulty fitting in at school, as Eli struggled to understand social cues and found it difficult to relate to their peers. Later in life, Eli would realise they are autistic and this in part explained why they struggled to meet the social expectations of others whilst they were growing up. The family home was a source of stress for Eli, their mother struggled with severe depression and their sister was described as highly manipulative. Having started out their school life as a 'gifted and talented' child, their grades slipped dramatically by the time they were a teenager. In high school, Eli had begun self-harming and became suicidal.

Eli was in and out of hospitals for mental health crises and agreed to go to a TBS as, at the time, they felt there was no better option. They described, 'I knew that there weren't any kind of services in [hometown] that were going to help me. The cycle of hospitalisation. This [TBS] looked like the only option that didn't end in me dying.' At the time, Eli was 'out' as queer in sexual orientation but was still exploring their gender identity. They were still presenting as a woman, the gender they were assigned at birth. They told me, 'I spent a lot of time in a very inauthentic space before going to [TBS], in terms of my gender identity.' Eli and their parents specifically sought a secular, LGBTQ+ affirming environment and this aligned with how the TBS promoted itself. Eli's parents unknowingly sent Eli to a conversion programme. Eli was seventeen and had just been discharged from hospital when the family drove them to the TBS.

At the TBS Eli attended students were discouraged from having any sexual identity. The staff were all members of the Church of Jesus Christ of Latter-Day Saints (Mormon Church) and conservative sexuality and gender norms were built into the structure of the TBS. Staff did not tell young people that being LGBTQ+ was 'wrong', but they did not allow LGBTQ+ people to openly express this part of themselves. Eli described:

No one was allowed to talk about any aspect of their queer identity in any way, like, I wasn't the only queer person there, and no one was allowed to talk about it at all. ...Technically they [TBS] were secular but everybody who worked there was Mormon, and it was a big, like they wouldn't ever outright say anything like "God wants you to be this way" or whatever, but

it very clearly affected how they would treat us and affect their therapy and things like that. There was just so much, I would say, covert queerphobia.

Despite the programme having promoted itself as LGBTQ+ inclusive, Eli believed there was underlying 'queerphobia'.

Staff treated teenage sexual exploration in general as problematic but for Eli their sexual desires and expressions were treated as pathological. The pathologisation of sexuality was not practiced in the name of 'conversion' and ostensibly was not specifically directed towards Eli for being LGBTQ+. However, Eli was expected to conform to traditional cisheterosexual Mormon values. Eli was placed in a 'recovery group' because they were seen to have an 'addiction' to masturbation and consuming queer erotica. Eli was told by staff that watching erotica was hindering their ability to connect with people. The recovery group would focus on, in their words, 'a lot of general, not science misogyny stuff that they used to try and convince us of.' Eli recalled coming to believe, at the time, that they did suffer from a sexual addiction, 'she [staff member] convinced me that I had a pornography addiction, which I didn't, because that's an absolutely real thing, I just didn't have one.' The recovery group pressured Eli to suppress queer sexual behaviour and expression in the name of overcoming addiction and enhancing psychological wellbeing.

The TBS Eli attended operated a privilege-level system based on how staff perceived student's level of compliance and emotional progress. If staff believed being cisgender and heterosexual was congruent with 'emotional growth' and living a 'healthy lifestyle', staff could withhold privilege level progression from students who openly expressed being LGBTQ+. Eli recalled having felt pressured to identify as a cisgender woman:

I was never told, "You're only a woman, stop saying that you're not". It was more like, "we'll just wait until you come to that conclusion and then reward you for that"... I was pressured into identifying strictly as a woman in order to progress through the program.

Although the programme did not outright state that it was 'wrong' to be LGBTQ+, Eli felt that the programme treated being cisgender and heterosexual as the only 'right' way to be. Compliance with conservative gender norms was rewarded, even if being LGBTQ+ was not expressly punished. Eli would need to achieve the highest privilege level if they wanted to graduate from the programme, this meant they felt they had to comply if they wanted to eventually be allowed to leave. The privilege levels system was used to coerce compliance with heterosexual and cisgender norms.

In the TBS LGBTQ+ young people were subjected to persistent undermining of their sense of self. Eli referred to their experience as 'conversion therapy lite':

It was "conversion therapy lite". It wasn't advertised as conversion therapy and my parents wouldn't have sent me to a place that was conversion therapy, like they wouldn't have sent me to a place with the intention of making me not queer, my parents are very accepting of that. It [the TBS] was just like, "oh, it just so happens that after you deal with all of your trauma, you'll only be interested in men".

Although not advertised as conversion therapy, this 'lite' or 'covert' form of conversion therapy was embedded into the programme's therapeutic practice. The programme approached being LGBTQ+ as an unhealthy identity rooted in trauma, and that the resolution of this trauma had potential to lead them to being cisgender and heterosexual. In other words, if the 'brokenness' was resolved then they could be restored.

Eli attended the TBS for nearly a year. After graduating, they attended a local college but struggled to adjust to life outside of the programme, both academically and socially. They had difficulty coping with ongoing depression and anxiety. Eli dropped out of college and later admitted themselves to a voluntary adult residential therapeutic programme. They were able to ask staff at the adult residential programme to use the name and pronouns that affirmed their gender identity and they 'came out' to their family as non-binary. At the time of interview, Eli continued to experience post-traumatic symptoms from their time inside the TBS and was in ongoing therapy.

Conversion Ideology and Epistemic Injustice

Conversion therapy treats LGBTQ+ people as wrong about how they interpret themselves and their feelings and desires, and that through 'conversion' practices people can instead come to know of themselves as cisgender and heterosexual (Kinitz et al., 2021). TBS conversion practitioners denied or undermined Jeremy and Eli's insight into themselves and any identification or expression outside of cisgender and heterosexual expectations. The programmes censored, discouraged and attempted to prevent access to LGBTQ+ affirming spaces and cultures. Young people who openly resisted the TBS ethos risked pathologisation, punishment and potentially prolonging their stay in the programme. The perspectives and expressions of LGBTQ+ youth in TBS were undervalued and undermined by design.

TBS staff perceived Jeremy's sexuality through a prism of 'sexual brokenness' and treated Jeremy as if he lacked sufficient self-understanding of his sexual (T. Jones et al., 2021). Staff were persistently homophobic and reinforced ideas that being gay was incompatible with living a healthy and fulfilling life. Staff were insistent that Jeremy was sexually abused by his father and that this was a root cause for his being gay. Jeremy recalled:

My counsellor said, "are you sure that your dad hasn't molested you?" And even though I said "no", I eventually learned that I could be lying.

When Jeremy denied that his father had sexually abused him, the therapist assumed he was lying, in denial or had repressed memories. Instead of believing Jeremy, the practitioner relied on their own value and belief frameworks to impose conversion ideology.

If young people expressed thoughts, feelings or objections that challenged TBS institutional norms, they were deemed 'the problem' and their perspective pathologised. Testimonial injustice occurs when a speaker's word is not valued or believed due to unfair or prejudicial assumptions about the speaker's capacity to know a subject (Fricker, 2007). In TBS, the students were treated as having a credibility deficit, a lack of valuable insight and knowledge. Eli described their experience:

At [the TBS] you aren't allowed to argue with things. If you argue with a staff or a therapist, you're lying or in denial and it makes you suspicious and it's essentially grounds for you to get dropped a [privilege] level.

Any disagreement with staff was subject to pathologisation and risked severe repercussions. Students learned that they would not be believed, they could be punished, and that it was safer not to speak up. The power inequalities between staff and young people coerced students into selfsilencing.

Jeremy found ways to adapt to institutional life and resist being subsumed by the programme. Jeremy remained 'out' as gay and was able to respond to staff's homophobic comments by reaffirming his sexuality, repeating to them, 'I'm gay, I've figured it out'. Jeremy was also able to have consensual sexual encounters with other male students without staff finding out. Jeremy learned to be selective in when he would openly resist and when he would feign emotional progress to appease staff (Mills, 2014). Jeremy described:

The more you went along with what they wanted you to, what they wanted to hear, the more you kind of survived. So, there was incentive to go along and to cry and have emotions and pretend... I actually found the more you followed the rules and did not deviate from the norm, the better you were. Even if you didn't believe it. So, I certainly sold them my share of bullshit that I did not believe, just to survive.

This mirage of compliance reduced Jeremy's risk of punishment and helped him progress through the programme to graduation, even if he believed it was 'bullshit'.

Eli initially refused to cooperate but eventually their resistance was worn down. Eli became compliant and learned to internalise the messages of the TBS as a coping mechanism and means of survival. They reflected, 'really, I didn't have a choice'. From this point, Eli mostly followed the rules and engaged in the mandated therapy and group sessions. They told me:

I was brainwashed, essentially. While I was at [TBS], and for a good while after leaving, I was like "oh [TBS] is the best, I love [TBS], this is the greatest place, everyone should send their kids here". Because that's how I needed to be in order to survive. It wasn't until months later [after leaving the program] that I started thinking maybe it wasn't the best and even then, it took me a while to start addressing specific things that happened or get any further than maybe it wasn't okay.

Eli became resigned to the programme, their hermeneutical resources had become so distorted and overwhelmed that they began to interpret themselves and their experiences through the knowledge frameworks of those with power over them (Panchuk, 2020; Falbo, 2022). Eli explained that despite their having proclaimed at the time that the programme was 'the greatest', in hindsight they reflected, 'I felt so constantly hypervigilant and so constantly unsafe, and I wouldn't have felt that way if it were really a safe place.'

The systematic devaluing of 'troubled teens' credibility creates an institutional culture where young people are extremely vulnerable to abuse and exploitation (Fieller & Loughlin, 2022). Jeremy described having been sexually abused by a male peer and a male staff

member at the TBS. He explained how disempowered he felt at the time, 'I was sexually assaulted by a counsellor after I came out... and I could not do anything about it.' Jeremy anticipated that reporting the abuse would have made his life more difficult, and that he would not have been believed. Similarly, Eli recalled TBS staff were sometimes 'incredibly cruel' towards the most vulnerable students. Due to a lack of trust in the programme, and a lack of formal grievance procedure, Eli described that if they experienced or witnessed mistreatment, 'there was nothing we could do about it.' They told me one former staff member had recently been arrested for historic sexual abuse of students. TBS can wield the perceived credibility of 'professional expertise' to dismiss, as well as deter, reports of abuse. Epistemic injustice disempowers pathologised young people and enables abusive staff to act with impunity.

Young people faced with the extreme conditions of TBS develop ways to adapt (Robinson & Schmitz, 2021). They develop coping mechanisms that vary not only from one student to the next, but also within the same person depending on the circumstance. Jeremy found ways to resist the programme, both through open defiance as well as through the refusal to internalise the programme's messages. Faced with often severe repercussions for non-compliance, Eli learned to cope by believing in the programme and they genuinely engaged in treatment. Both Eli and Jeremy had times of refusal and times of compliance, even if they relied more readily on one rather than the other. These coping strategies can represent conscious choices as well as trauma responses (Herman, 2001). They represent points where their self-knowledge was overwhelmed by the persistence of pathologisation and conversion ideology, and also ways they resisted epistemic oppression and ultimately maintained their LGBTQ+ identities (Medina, 2013).

Implications for practice

The case studies highlight the dynamic and evolving nature of conversion therapy. The practices enacted against Jeremy in the 1990s were much more overt than the practices Eli experienced in the 2010s. This may be part of a broader shift in the language and practices of conversion therapy. Jones et al. describe these changes, 'in recent times, the conversion therapy movement has presented itself in more ethically acceptable postures, disguising its anti-LGBT ideology and reorientation efforts in the language of spiritual healing, mental health and religious liberty' (Jones et al., 2018, p. 4). Concerningly, these conversion practices can occur in programmes that claim to be LGBTQ+ friendly. A young woman at one troubled teen industry programme was reportedly told by staff that 'her homosexuality was a sin, and that she needed to seek God', despite the programme's 'claims to be a safe place for LGBT+ teens' (Okoren, 2022). The increasing number of US states with 'conversion therapy bans' may appear to protect young LGBTQ+ people, but they are unlikely to prevent these practices. These bans typically only address overt forms of conversion therapy perpetrated by licensed healthcare professionals, and prosecutions are rare (Taglienti, 2021). These bans also approach conversion therapy as a problem of individual practitioners, rather than part of the ongoing pathologisation and devaluation of LGBTQ+ lives (Barr, 2018; Schumer, 2014; Ashley, 2021).

Research on conversion therapy has predominately focused on overt forms of the practice (Ryan et al., 2020). Consequently, covert forms of conversion therapy may not be as readily

identifiable to social workers, researchers, policymakers or the general public (Goodyear et al., 2022). Social workers should be aware of the risks posed to young LGBTQ+ people when recommendations or referrals are made to residential programmes, including TBS. Social workers should critically reflect on our own practices and those of the institutions we interact with (Austin et al., 2016). Knowledge of a range of conversion practices is important for social workers who may encounter service users who have been subjected to conversion therapy. Conversion therapy may not always be readily identifiable to those who have experienced it and access to interpretive concepts that explain the harms they have experienced may be useful. Further research on this topic, and best practice in supporting survivors of various kinds of conversion therapy would be of significant benefit to social work.

Conclusion

TBS was experienced by Jeremy and Eli as traumatic and as a source of ongoing psychological harm. Conversion therapy was embedded in the culture of the TBS as well as in interpersonal staff–student interactions. The case studies highlight two forms of conversion therapy: overt and covert. Overt conversion therapy included practices that openly intended to change or suppress LGBTQ+ people’s sexual orientation, gender identity or gender expression. Covert conversion therapy operated in an insidious manner that pressured such change and suppression, but the intention of conversion practitioners was not made explicit. Both forms of conversion therapy represented epistemic injustice where students were undermined in their capacity as knowers of their own sexual orientation and gender identities. There is a need for social workers to reflect on how we can disrupt conversion ideology within our profession and within our communities (Kia et al., 2022).

Chapter eight: Seclusion and restraint

Introduction

The use of seclusion and restraint (SR) to coerce compliance is an integral part of the troubled teen industry. While the industry often justifies these measures as a means to an end, they can be dangerous and damaging (National Disability Rights Network, 2021). News coverage of the troubled teen industry has included reports of seclusion in the form of solitary confinement and so-called ‘padded rooms’ and ‘isolation boxes’ (Piore, 2023; Hilton, 2021; Associated Press, 2016). The use of restraints such as handcuffs, zip-ties, painful physical holds, and sedation have also been reported (Stockton, 2022; Miller, 2021). In some cases, the use of SR in the troubled teen industry has been described as tantamount to torture (Fleck, 2021; Murdock, 2016; Williams, 2013). The urgency of this issue was further underlined in 2020 when a young Black man was killed by restraint in a therapeutic boarding school in Michigan (Bey & Cohen, 2020). Cornelius Frederick was a young Black man, a demographic that experiences among the highest rates of restraint in health facilities (Payne-Gill et al., 2021; Schnitzer et al., 2020). Video footage showed seven men holding Cornelius face down on the floor for twelve minutes; the restraint was in response to his throwing a sandwich (Kingkade & Rappleye, 2020; Dwyer, 2021).

This chapter will describe the role and forms of seclusion and restraint in therapeutic boarding schools and connected troubled teen facilities. The experiences of four interview participants will be discussed as case studies. In this chapter, I will outline forms of seclusion and restraint in therapeutic boarding schools. SR practices have become violent interventions normalised in the day-to-day functioning of the programmes. SR was utilised to coerce compliance and suppress dissent. These practices were a violent means to assert unequal power relations and epistemic injustice in the name of therapeutic practice. While ostentatiously implemented for young people’s well-being, this caused lasting psychological trauma. Seclusion and restraint did not lead to the prevention of harm, but the escalation and enactment of it. These practices protected the institution’s interests at the expense of young people’s welfare.

Background literature

The U.S. Department of Education asserts that seclusion and restraint should be proportionate, only enacted when there is no suitable alternative option, and as a response to an immediate and severe danger to people’s physical safety (U.S. Department of Education, 2012). Regarding the appropriate treatment of disabled students, “the Department’s longstanding position is that every effort should be made to prevent the need for the use of restraint or seclusion and that behavioural interventions must be consistent with the child’s rights to be treated with dignity and to be free from abuse. Further, the Department’s position is that restraint or seclusion should not be used except in situations where a child’s behaviour poses an imminent danger of serious physical harm to themselves or others” (U.S. Department of Education, 2022, p. 10). A review of 2017-2018 school district data in the USA concluded that 101,990 students were reported to have been restrained and 21,277 students subjected to seclusion, and this reflects the minority of

incidents that have been reported (U.S. Department of Education, 2020, p. 6). In schools and psychiatric facilities, seclusion and restraint are often used as disciplinary techniques and for staff convenience (National Disability Rights Network, 2021). While seclusion and restraint are sometimes used as emergency measures in extreme circumstances, incidents of seclusion and restraint appear to be wide-ranging in form and purpose (Newman et al., 2019).

The risk of being subjected to seclusion and restraint is not evenly distributed amongst social groups. In the USA, young African American students experienced some of the highest rates of recorded seclusion and restraint in schools (Roy et al., 2021; Newman et al., 2019). In health care services, African American men are also subjected to the most frequent and severe forms of SR (Schnitzer et al., 2020; Bey & Cohen, 2020). The gender differentials are somewhat unclear and appear to vary considerably depending on additional factors, such as age and type of facility a person is being held in (U.S. Department of Education, 2020; Green-Hennessy & Hennessy, 2015; Roy et al., 2021). Research resoundingly indicates that disabled people are significantly more likely to be subject to seclusion and restraint than their non-disabled peers (Carlson et al., 2021; Katsiyannis et al., 2019; U.S. Government Accountability Office, 2009; Mehta, 2015). Autistic people and those labelled with learning disabilities are among those most at risk of being subjected to seclusion and restraint (Katsiyannis et al., 2019; Keski-Valkama et al., 2007). Young people labelled with a psychiatric disorder also experience high rates of SR (Brown et al., 2012; Roy et al., 2021). Further, people who have previous experience of childhood physical or sexual abuse are more likely to be subject to seclusion and restraint (Hammer et al., 2011; Roy et al., 2021).

One of the most significant risk factors for experiencing seclusion and restraint is if a person becomes institutionalised or incarcerated (Slaatto et al., 2021). Among care facilities, one research study suggests the type of facility, and the facilities funding source, are stronger predictors for the likelihood of seclusion and restraint occurring than are individual patient characteristics, such as gender and race (Green-Hennessy & Hennessy, 2015). It is crucial, however, to note that who gets sent to what type of institution, or any institution at all, remains deeply intertwined with our positions in society and therefore is never truly separate from an individual's characteristics (Adams & Erevelles, 2017). According to Green-Hennessy and Hennessy's research, privately operated facilities were four times more likely than public facilities to use 'coercive methods' like seclusion and restraint (2015, p. 549). They also suggested that lower staff-to-patient ratios are associated with heightened use of seclusion and restraint. Staff attitudes towards seclusion and restraint, and attitudes towards masculinity may also play a role (Roy et al., 2021). Further research suggests seclusion and restraint are more likely to be used by low-waged staff in jobs with a high turnover (Masters, 2018). Institutional culture is critical in how or if seclusion and restraint are used.

There are students, patients, and staff members who have reported that seclusion and restraint can have a beneficial 'calming effect' (Carlson et al., 2021; Cusack et al., 2018). In one study, a participant described physical restraint as a cathartic opportunity to release anger, "I feel like I like getting restrained to take my anger out away... when you're in a restraint your anger will just come out" (Steckley, 2018, p. 1655). While different contexts exist in which SR will have different meanings and impacts, there is limited research to

suggest how common positive experiences of being subject to seclusion or restraint are. A report by the National Disability Rights Network concluded, “providers justify the use of seclusion and restraint as necessary, therapeutic techniques that ultimately reduce undesirable behaviours. However.... study after study demonstrates the detrimental effects of using seclusion and restraints” (2021, p. 32). Several studies evidence the risk of re-traumatising service users, especially if SR is imposed on people with prior experience of physical or sexual abuse (Hammer et al., 2011; Scholes et al., 2022). In one study, patients described that SR brought on feelings of “fear, anger, confusion, apprehension, frustration, irritability, sadness, abandonment, powerlessness, anxiety, guilt, humiliation, and psychological pain” (Jacob et al., 2018, p. 108). A participant in another study described, “it pisses you off, it makes you worse. Restraints don’t make you better, it controls you, controls behaviour but it doesn’t stop what’s inside” (Jacob et al., 2018, p. 100).

Seclusion and restraint can lead to increased violence rather than reducing or preventing violence. Research suggests that seclusion and restraint can escalate agitation and aggression in those being subjected to it, who may become hostile and ‘fight back’ against staff (Slaatto et al., 2021). In Scholes, Price and Berry’s study, one participant explained, “I’m not a mouse, I’m a tiger, and I will fight back. . . I’m not gonna stand there and let you take me down to that floor” (Scholes et al., 2022, p. 383). Patients who resist may be subject to ever-increasing cycles of seclusion and restraint (Hammer et al., 2011). Further, its use can damage a person’s sense of trust in the staff and escalate tensions (Slaatto et al., 2021). Seclusion and restraint can also pose a significant risk to a person’s physical safety (Cusack et al., 2018; Masters, 2018). Physical restraints can cause death, especially physical holds that restrict a person’s airways can result in asphyxiation or cardiac arrest (Bey & Cohen, 2020; U.S. Government Accountability Office, 2009).

The extent to which seclusion and restraint are used in the troubled teen industry, how it is used, and against whom it is most likely to be used is not known. There are substantial gaps in data on the rates of SR used on children and young people in the USA (Newman et al., 2019; Robins et al., 2021). National data collection on the topic is limited, and data often rely on the self-reporting of staff (U.S. Department of Education, 2020; Brown et al., 2012). Laws pertaining to the seclusion and restraint of minors are variable across states. There is no federal law requiring the practice be reported, nor is there federal law prohibiting harmful uses of seclusion and restraint (Carlson et al., 2021; U.S. Department of Education, 2020). Many instances of seclusion and restraint likely occur ‘in the shadows’, unreported and unknown to local authorities (Newman et al., 2019). Based on 2010 data, one study found that more than four out of five residential treatment centres for children and youth reported having used seclusion and restraint within the previous year (Green-Hennessy & Hennessy, 2015, p. 550). ‘Residential treatment centres’ were defined broadly and was not specific to the troubled teen industry, however. Several research papers and reports describe seclusion and restraint in the troubled teen industry as routine practice (National Disability Rights Network, 2021; Chatfield, 2019; Whitehead et al., 2007). Additionally, numerous news reports have described the harmful and occasionally deadly effects on students (Kingkade & Rappleye, 2020; Cooper, 2021; Hilton, 2021).

Method

This chapter's topic was chosen because most students described at least one form of seclusion or restraint during their time in the troubled teen industry. I selected four case studies from the sixteen interviews I had conducted. They were selected on the basis that they discussed in-depth an experience of seclusion and/or restraint, and their interview was not used as a case study in another chapter. I included more case studies in this chapter to draw attention to the variety of seclusion and restraint tactics employed within these institutions. All four case study participants are gender minorities and identified as white or white/Ashkenazi Jewish. Therefore, the chapter reflects a specific demographic. The case study participants were all provided draft copies of their case studies and quotes from the chapter. All the participants engaged in a feedback process. In most circumstances, the changes were minor, but where substantial new information was introduced, I clarified this in the text.

Case studies

Case study one- Sasha

Sasha is white, Ashkenazi-Jewish and bisexual. She did not feel identity categories for gender fit with her experience and internal sense of self. She grew up in an upper-middle-class family in the Northeast in a well-off suburban town that Sasha never liked living in. When Sasha was nine years old, she started to develop what she described as obsessive-compulsive traits and began dressing in a more masculine style. Over the years, she had input from various mental health professionals and was eventually placed on anti-depressants, which she believed made her increasingly impulsive. Sasha elaborated:

"I just wasn't happy, and I just had no control over getting out of my situation. I don't know, I was just very unhappy... I think I was just testing limits or something."

Due in part to her impulsivity, Sasha was diagnosed with bipolar disorder. She explained, "my parents were in one way extremely caring and care-providing, they took me to specialists, and specialists in bipolar disorder in children will probably be the most likely to see bipolar disorder in children." Sasha was later taken to a psychiatric hospital that she said was "just absolute hell".

After she was released from the hospital, she had difficulty readjusting to life at her local high school. She was transferred to an "awful" 'Gifted & Talented' programme for children diagnosed with mental health problems and/or cognitive disabilities. She hated the programme but also felt unable to return to her previous high school:

"It was just a time of my life when I could have benefited from options and there just weren't any. I had a therapist at the time who recommended the idea of a therapeutic boarding school and I kind of hated the idea, I really didn't want to leave home. I really wanted there to be some kind of day school option and there wasn't. ...I think my parents also were worried that

I was kind of a liability, I don't think they ever wanted to feel like, 'oh well, we should have done something'. I don't think they understood what was the nature of my unhappiness. And so, it was better to do too much than too little."

Sasha's parents gave her the choice between two therapeutic boarding schools in the Northeast. Her mom was able to advocate for the state to pay in full the school's \$80,000 annual tuition. It was the mid-2000s and Sasha was fourteen when she entered the programme.

Case study two- Bridgit

Bridgit is a white cisgender woman who, at the time of the interview, was questioning her sexual orientation. Bridgit is from a wealthy family of Irish-Catholic descent and grew up in an affluent community in a small Southern city. Bridgit explained that she grew up with many privileges but did not always have the support she may have needed as a teenager:

"I'm a relatively privileged person in the scope of things. I think I probably was set up with the golden ticket, as far as resources available to me with money, [but] maybe just not the same kind of informal support that I needed."

Bridgit described that she was intelligent, quiet, and reserved when she was younger, that she was both "terrified of doing anything wrong" and was "a little rebellious". Bridgit explained that in her family, even "reasonable" amounts of rebellion and resistance would horrify her parents. Her family expected her to fit into the milieu of upper society, all of which she hated. The family rarely expressed their feelings and avoided difficult conversations. Instead of talking, Bridgit said her parents would often drink excessively, "getting blackout drunk in my family is very, pretty normal and not ever talking about anything, any feelings, addressing anything".

By the time Bridgit was a teenager, she was in a deep depression and had begun self-harming and feeling suicidal, "when I was thirteen, I think that's the first time I wrote a suicide note, and my mom found it and freaked out and sent me to a psychiatrist, and I've been on some type of medications since that age." Bridgit's depression continued, and in high school, she started using drugs and partying. At one party, Bridgit was raped. "That's probably when things got the worst," she told me. She got a fake ID and was frequenting the bar scene, taking methamphetamines, and driving under the influence. Even though she was able to maintain good grades at school, by her sophomore year, she was getting into frequent fights with her parents and running away. She remembered:

"There was one point where my mom was making me sleep in her room 'cause I was sneaking out so much. What happened is I was so tired of the cycle that my life had become, which was partying, drinking, coming home, fighting with my parents, running away, going to school, getting shit from my teachers, kids calling me a slut, partying, drinking, it was just over and over. And I tried to kill myself."

Bridgit had overdosed, was found by her mother, and taken to the hospital.

Bridgit was then sent to rehab, which she said was useful but did not address her deeper psychological struggles and trauma. She explained, “Even at forty-five days [of rehab], I don't think I had told anyone about the rape”. Instead of returning home after rehab, the staff and her parents decided Bridgit should go to a therapeutic boarding school. Bridgit felt she needed some form of intervention at that point in her life:

“I probably would have killed myself. I was smoking meth. I was sixteen, I was waking up next to people I didn't know, waking up in places that I didn't know where I was. I definitely needed help and can totally understand why any parent... I might have done that same thing, like, ‘just lock this kid out ‘cause she's so out of control and I don't want to do it anymore, and she's going to kill herself’, like it's your biggest fear. You know, but I think that's kind of how they [the troubled teen industry] get ya... fearful parents.”

Bridgit did not know how her parents came across the TBS or how they vetted it, “I think it was just the closest one, and they [TBS] make the programmes sound so therapeutic... if you don't know anything, if you're panicking, ‘yeah put her at this one, sounds good’.” Bridgit was told she was going to an in-state ‘six-month programme’ that, on paper, Bridgit said, “looked nice”. It was the 2000s when Bridgit was sixteen years old, and her parents drove her to the first of two therapeutic boarding schools she would attend.

Case study three- Eva

Eva is a straight and cisgender white-Jewish woman who has chronic illnesses. She was raised in a high-income family in a large metropolitan city in the North-East. Eva described that her parents were emotionally distant. She found it hard to express her emotions around them because she was often dismissed as overly sensitive. She was raised in an “Orthodox Jewish bubble” and attended Orthodox Jewish schools where she “didn't really fit in”. When she was thirteen, a male pupil spread sexual rumours about her, and Eva started to receive rape threats. She recalled, “I spent a good majority of my middle school afraid of being raped”. She experienced ongoing bullying and had few friends whom she could trust. Of her close friends, one was described as emotionally manipulative:

“I started to become friends with another girl who was deeply disturbed, who was suicidal, self-harming and would constantly message me. She lived in [city centre] in a big building. She would message me, ‘bring pills to school tomorrow, or I'm going to jump off my building right now’. She taught me about self-harm but told me that I was ‘too good’ to do it, only she could do it, but [she] would do it with me sitting next to her. Then I started doing it. A really unhealthy kind of relationship.”

As the situation worsened, Eva was hospitalised for self-harm and suicidal thoughts.

Eva was the only Orthodox Jewish at the hospital, and she was subjected to antisemitism, including by a fellow patient who said to her, “‘Move Jew, or I'll call Hitler’”. Her parents transferred her to “a fancy upscale hospital” where the antisemitism was less pronounced, and Eva started anti-depressants and dialectical behavioural therapy (DBT). Eva felt the

treatment was ineffectual, partly because her parents would not engage with the process, “they didn’t have the time to sit, even listen to me”. Eva was vegan and kosher at the time, which was poorly catered for at the hospital. This, combined with an appetite-suppressing anti-depressant, meant that she became severely malnourished. Overall, Eva found the hospital experience “did not work very well”, and the doctors recommended she be sent to a therapeutic boarding school/residential treatment centre. She was taken from the hospital by ‘transporters’ to a programme in the South. It was the 2010s, and she would be in the troubled teen industry between the ages of sixteen to eighteen.

Case study four- Rachel

Rachel is a white, heterosexual, cisgender woman who grew up in a high-income family in Canada. It was the 1990s when she was sent to a troubled teen industry programme in the United States. Rachel and I spoke initially in 2018 when she was interviewed for this research. In 2023 we spoke again, and she discussed coming to terms with new realisations about her family and her troubled teen industry experience. Since we had last spoken, Rachel had recalled previously repressed memories of childhood abuse. In 2018, she spoke of having grown up in a family with “a lot of conflict”. Her parents had divorced in her early teens, and she had felt “a bit lost” and had started “experimenting a little bit with pot and things like that”. She had narrated these as the conditions leading up to her being sent to a therapeutic boarding school. In our conversation in 2023, Rachel described that her father had sexually abused her as a child and that she had been sent away to cover up the abuse. Rachel recalled that her father had been part of a popular cult movement and that her parents were highly controlling and had routinely gaslighted her. To protect the family’s reputation, Rachel had been cast as the problem child and sent away.

When Rachel was fourteen years old, her parents pulled her out of school and staged an “intervention”. She was told that she would have an assessment and speak to some counsellors for a few days. Rachel explained the experience to me:

“They had pulled me out of school one day and said, ‘we just want to talk to you because we all care about you’. ... Then they just said, ‘we found this school that’s really great and it has all these counsellors, and you can talk to them about your feelings. They’re just going to assess you, just to see what you need. They have a specialist out there, that’s why we’re sending you that far. But it’s just going to be a couple of days and then you can come home’. ...they were all just like, ‘we care about you, and we know you sneak out at night and smoke pot and meet up with older guys. You need to go and do this’. So, they were like, ‘we’re leaving for the airport now.’”

Rachel initially agreed to go. She explained, “I was actually wanting some guidance on sorting out my thoughts”. Rachel flew across Canada with her father. When they landed, she was informed the programme was in the United States and that she would be taken across the border by forcible transportation services. She was told if she refused the airport security guards would publicly arrest her. She recalled, “I was terrified because I didn’t know really what was happening.” Later that day she arrived at a therapeutic boarding school, the first of several troubled teen industry programmes that she would attend.

Forms of seclusion and restraint in therapeutic boarding schools

Seclusion and restraint can occur in multiple forms, in obvious and insidious ways. This chapter will discuss forms likely more apparent to readers, such as the use of solitary confinement and handcuffs, as well as ways SR was more subtly inflicted. Restraint and seclusion are often justified on similar grounds and frequently used together. I will define common terms as well as suggest new subcategories of SR. These will be discussed alongside examples from participant case studies. Multiple forms of restraint and seclusion can be directed towards a person simultaneously or in succession. These categories are not wholly distinct, and some interventions could be considered to belong to multiple categories. Some forms of SR are outright abusive, but others require attention to context. The examples of SR I have included in this chapter are forms of institutional abuse, regardless of the staff and programme's intentions.

Seclusion

Seclusion has been defined as the confinement of a person to an area they are prohibited from leaving and separating them from other people (Scholes et al., 2022). This involves having almost no meaningful contact with other people. The intervention is justified by institutional authorities as necessary to protect the person and others from harm (Carlson et al., 2021). In therapeutic boarding schools, there are students for whom seclusion involves a separate physical space which may or may not be locked. These include isolation rooms within a building regularly occupied by students and separate buildings or facilities where the student may be kept. Former students have also described being prevented, or 'banned', from communicating with other students, even in shared physical space. I consider this, too, a form of seclusion. Therefore, I call for a more expansive definition, including various forms of seclusion- confined seclusion and social seclusion.

Confined seclusion

I use the term 'confined seclusion' to refer to when a person is forcibly confined to a room or small enclosure and is deprived of contact with other people. These spaces are locked or unlocked if exit points are closely monitored, and to leave without permission would risk severe consequences. This is akin to what most guidelines and policies refer to when they use the term 'seclusion'. Confined seclusion has also been known as 'solitary confinement'. While the term solitary confinement can be applied to multiple contexts, including hospitals and detention centres, it is often associated with prison cells. In my research, confined seclusion was referred to by a variety of terms such as 'isolation rooms', 'obs' (observation rooms), 'solo', and 'safety'. I have chosen to use the term 'confined seclusion' to describe solitary confinement in locked rooms as well as other ways people can be confined in a variety of physical spaces.

In therapeutic boarding schools, confined seclusion can occur in a variety of settings, under a variety of names, and for a variety of expressed purposes. Eva attended a therapeutic boarding school where students could be placed in isolation in a shed-like structure separate from the buildings ordinarily used by students. She described:

“They put me on ‘solo’, which was what they called it. It was basically a shed on the back of campus that you’re going to live in for the next week, two weeks, whatever it is. You’re not allowed to have any human contact or communication, [staff would say] ‘if we find out you talked to somebody, we’re going to extend the amount of time that you’re out there’.”

Eva was held in isolation for a week with “no outlet for communication, just a journal”. She was allowed restricted access to the outdoors, but this was far from other people and campus buildings. Students deemed a ‘risk’ could be placed in seclusion for multiple weeks, an intervention known as ‘safety’. Students would not be informed of how long they would remain in seclusion, and every time a student asked staff how long they would be there, their time in confinement would be extended.

At the first therapeutic boarding school (TBS) Rachel attended, the programme worked in coordination with a hospital where she would be forced into confined seclusion. The hospital had a troubled teen industry ward where a variety of TBS would temporarily send young people who had been labelled acutely unwell or disruptive. While in the hospital, students would be required to follow the rules (‘protocol’) of the therapeutic boarding school, and hospital staff were to treat students differently from standard patients. This essentially turned the hospital ward into an extension of the school. Rachel explained:

“The hospitals were a big part of it because they were under [TBS] protocol. They had a section just for students coming from those boarding schools, like [another TBS] and everything. They would continue the protocol, like... all the weird therapeutic restrictions. You couldn’t escape that reality, even at a mental hospital you couldn’t escape [the TBS].”

Young people could be sent by the TBS to be held in small, locked rooms in the hospital. These rooms were referred to by the programme as ‘safe houses’ and ‘observation rooms’. The longest time Rachel recalled being in the hospital’s confined seclusion was thirty days in a row.

Social seclusion

I suggest a further type of seclusion used in the troubled teen industry called ‘social seclusion’. Social seclusion occurs when a person remains in shared social spaces but is prohibited from talking to and interacting with others. Often referred to as ‘speaking bans’ in the troubled teen industry, young people are not allowed to speak to their peers. They may be prohibited from all forms of verbal or nonverbal communication or contact with other people, except in response to being directly addressed by staff. I consider this extreme form of social restriction a form of seclusion due to the severity of social deprivation. While sensory deprivation can be a harrowing aspect of physical confinement, research on confined seclusion has suggested that the most distressing aspect is not the sense of being physically trapped, “it is the lack of human contact... as well as the overwhelming feeling of abandonment and neglect that produce a negative experience for those in seclusion” (Jacob et al., 2009, p. 80). The two forms of seclusion undoubtedly have impacts unique unto themselves, but they are a related phenomenon of institutionally sanctioned social deprivation.

The severity of the restrictions can vary, and some programmes enact partial social seclusion whereby students are banned from communicating with most, but not all, of their peers. This often involves young people being prohibited from communicating with 'lower level' students and only being allowed to speak with students at the highest privilege level. Some students may only be able to speak when spoken to by staff. The distinction between peer and staff is, additionally, complicated within the industry. Students on the highest privilege level may be experienced by the lowest level students as more like staff than peers, as these upper-level students will enforce the programmes' rules and regulations. In this sense, living under partial social seclusion prevents young people from having the ability to engage with their peers. While no physical structure separates them from other people, the realistic fear of punishment alongside pervasive surveillance prevents them from having any meaningful contact with others.

The therapeutic boarding school Bridgit attended required new students to go through an initiation phase that prohibited her from speaking with almost all other students. When she first arrived at the programme, she was only allowed to talk to staff and her 'older sister' (a peer mentor of a higher 'privilege level'). This precluded conversation as well as mundane communication. Bridgit recalled:

"I just remember they're like, 'you've got three days to learn the rules, you're wearing a red shirt, you can't talk to anyone, nobody can talk to you, you can only talk to staff and your 'big sister''. I think I was just in shock. I was like, I can't believe this is a real thing. They were explaining how 'work hours' happened, if you screwed up, you'd be on a 'work hour' and you woke up at 5 am. I wasn't really sure what that meant yet. I had to learn what 'passive communication' was because I wasn't allowed to talk to anyone. Like, if someone, even if I didn't talk to them, if I said, 'could you pass me the salt?' and someone passed me the salt, that counted as 'passive communication' and that was a 'work hour'."

When Bridgit entered the school, she was forced into structurally mandated silence. She was banned from communicating with nearly all her peers and was forced to wear clothing that marked her lowly status as a 'newcomer' not to be spoken to. She was offered little explanation other than that disobeying would result in physical labour 'work hours' punishment and extend her length of time on 'silence'.

While social seclusion does not require being confined to a physical space, it is often accompanied by some form of restriction on movement. This includes not being allowed in common areas or only being able to access these under specific circumstances. Bridgit recalled that when she was 'on silence,' she had to be within arm's reach of a staff member:

"They put me in a, they call it a 'silence vest', and it was like a day glow, something like a crossing guard would wear, like a highlighter-coloured vest, so that everybody would know I was on 'silence', not allowed to talk and nobody could talk or look at me, and I had to be within arm's length of staff at all times."

Controlling a person's movement through physical spaces allows communication to be more closely monitored. Additionally, for those who were made to wear clothing that indicated their status 'on silence', this would ensure others would not engage in communication with them (Rauktis, 2016). The enforcement of social seclusion often necessitated an increase of surveillance.

Restraint

Restraints are interventions that prevent, reduce, or subdue a person's capability to freely move and access their body (Brown et al., 2012; Robins et al., 2021). For the purposes of this thesis, restraint will refer only to forced or coerced interventions. Restraints can be used to immobilise or subdue a person temporarily or may be imposed over prolonged periods. The use of restraints is argued as necessary when a person poses an imminent threat of violence or harm to themselves or others, such as a need for staff to hold a patient back from punching another patient. The concept of restraint is commonly thought of as physical restraint. Physical restraints are physical interventions that prevent or restrict a person from carrying out their normal abilities to move freely (De Berardis et al., 2020; Council for Children with Behavioral Disorders, 2020). Restraints cannot easily, safely, and without risk of punishment, be stopped or controlled by the person subjected to the intervention (Robins et al., 2021). There are multiple forms of restraint, including those which do not use physical force. I will introduce four broad categories of restraint- physical holds, mechanical restraint, psychopharmaceutical restraint, and neglectful restraint- to describe the experiences of former therapeutic boarding school students.

Physical holds

'Physical restraint' is a term that is often used interchangeably with 'physical holds' (Robins et al., 2021). However, I consider physical holds as one form of physical restraint (the other being mechanical restraint). Physical holds involve the use of physical human force to inhibit the movement of another person's body, often with the specific aim of reducing movement of a person's legs, arms, torso, or head (Carlson et al., 2021; Robins et al., 2021). Physical holds can be life-threatening when there is forceful pressure on the head, neck, or chest, which can cause death by asphyxiation (Berzlanovich et al., 2012). There are physical holds that constitute a lower risk of death or serious bodily harm, such as holding a person's arms behind their back. However, this still risks bruises, scratches, and other forms of bodily injury. Physical holds include holds that intend to keep a person stationary as well as those where the person is being taken from one place to another. A physical hold does not require immobilisation of the entire body; it may be only parts of the body, such as the arms, that are prevented or inhibited from moving.

Eva became acutely distressed when she was in confined seclusion and attempted to run away. Several staff members physically restrained her and pinned her to the floor. She recalled:

"I tried to run and call the police, but they [staff] put me in a hold, they pinned me to the floor. I thought that if I was not wearing clothing, that they would, this is how crazy my thought process was, if I wasn't wearing clothing, they couldn't legally touch me, so I went in a bra and underwear and tried to run off campus to call the police. It took eight people to hold

me down because I was, it was fight or flight 1000%. Eight people, half of them men, and big men, left bruises, scratches, all of that."

Despite her attempts to resist, escape and contact the police, the staff physically restrained and immobilised Eva. The use of physical holds prevented her from being able to leave.

Mechanical restraint

Mechanical restraints function similarly to physical holds; the key difference is the use of a device to restrict a person's movement instead of another person's body (Jacob et al., 2018). Mechanical restraints include devices such as handcuffs, zip-ties, straps, ropes, or belts to restrict a person's ability to freely move any part of their body ("Children's Health Act," 2000). In addition, mechanical restraints include electroshock devices like stun guns and electronic tagging (Horsburgh, 2004). Mechanical restraints do not include prescribed orthopaedic devices, medical equipment used to perform legitimate examinations, or medical aids used for recovery from surgery, injury, or ailment, such as the use of splints in recovery from wrist injury ("Children's Health Act," 2000). Mechanical restraints are often used with physical holds, but not always. In the troubled teen industry, mechanical restraints include the utilisation of devices designed for restraint as well as the repurposing of everyday objects as restraints.

After Eva had tried to escape confined seclusion, staff arranged for forcible transportation services to take her from the school to wilderness therapy. Eva remembered when the 'transporters' arrived:

"Two people came and threw me into a van, and one of them sat on me. They were incredibly abusive, didn't tell me where I was going, what was happening, they just threw me into a van. They told me that 'you were going to wilderness,' but they didn't explain what that meant, or what was going on. Threw me into a van, one of them sat on me, they handcuffed me to the seat in a very uncomfortable position, and then drove me to the [wilderness programme], where they basically took everything from me."

Eva was subjected to mechanical restraint and physical hold as she was handcuffed, thrown, and sat on by forcible transportation staff.

When Eva arrived at wilderness therapy, like all newcomers, she was treated as a 'run risk'. This meant Eva was subject to the programme's most restrictive conditions. To prevent young people from running away at night, those newly arrived are required to sleep wrapped up in a camping tarp. One or two staff members sleep next to the person and often sleep on top of part of the tarp. Known in wilderness as 'tarping', the rustling noise and movement of the tarp would alert a staff member if someone was trying to flee. The tarp would both restrict the young person's ability to move and signal to staff any attempts to break free of the tarp. Eva described:

"When you get there, they do something called 'tarping', where basically they're afraid you're going to run and so they wrap you in a tarp, like in a burrito, and then the staff member sleeps on top of the tarp. You're in a tent with one staff member, where nobody else can see you and the staff member is completely in control. The point of it is that if you try to wiggle

out or run away, they'll feel it and wake up. But as somebody who's claustrophobic, I didn't sleep that night, I refused to get into my tarp the first night and then I just broke... I completely broke."

The use of tarps as a physical restraint allowed staff to have heightened control over Eva's movements at night. At wilderness therapy, Eva "broke" after the extreme conditions of the programme wore her down. She would remain in wilderness for over three months before returning to the therapeutic boarding school.

While Rachel was in the troubled teen industry hospital ward, it seemed any behaviours she exhibited were interpreted by staff as indicative of her being mentally ill, erratic, and out of control. At one point, she refused to cooperate with her therapist, for which Rachel was forcefully restrained. Rachel had been on a phone call with her parents during a therapy session, but the therapist abruptly hung up the phone. Rachel described that when she was on the call, she had been "reacting to something or saying how I felt about something, God forbid, and she [the therapist] ended the call and hung it up". Rachel became upset and walked out of the therapy session. She remembered:

"I left, I walked out of her office in tears. I walked down the hallway because I didn't want to talk to her anymore. So, they called a code something. They strapped me down to a stretcher. I was put in the observation room on a stretcher, face down with all the hair in my face and eyes, for a long time. That would happen often. It started giving me anxiety. It's like, you're trapped in a tiny room on a stretcher that you're strapped down onto. It's never okay to do that to somebody. Then they would just leave me there. Honestly, I never was out of control, I never had any psychological issues, I never had a diagnosis, and I was in some psych ward getting restrained."

Rachel was subject to numerous violent interventions from staff, including being strapped face-down on a stretcher and placed alone in a hospital room. These interventions perpetuated a cycle of increased use of seclusion and restraint and Rachel's increased psychological distress.

At the TBS Bridgit attended, staff called the police when they suspected one of the students had brought drugs on campus. Unlike other TTI programmes, the staff did not perform strip searches and called the police to investigate further. The police arrived on campus and when the student resisted the search, she was shot by an officer with a stun gun (Taser). Bridgit remembered witnessing the encounter,

"I remember one of my roommates brought drugs in... she was doing all this crazy shit, and they [TBS staff] couldn't legally search you, they had to call the police to do that. So, when she came back from a home visit, they called the police to do a strip search on her because they thought she was smuggling drugs into the centre. They Tased her... because she resisted. They were trying to handcuff her or something, I think they were just trying to apprehend her to do, like she was refusing the search. She was like 'no, you can't search me, like what are you [doing]?' And we watched, I watched from outside the classroom, I remember seeing it."

Stun guns incapacitate the person targeted by deploying electric shocks. The “non-lethal weapons” are often carried by police officers in the USA, where private possession is also legal in almost every state (Taser, 2023; Mele & Diaz, 2021). The devices are painful and dangerous. Over 1000 people in the USA have been killed by police-fired stun guns (Reuters, 2018). Bridgit remembered that the student “was showing me the burn marks from the Taser... she was like, ‘I’m pregnant; they probably killed the baby’”. Bridgit did not know if it was true that her peer had been pregnant; nonetheless, the injury and potential for injury were real. The TBS staff ban on physical restraint was insufficient to protect the young people, as violent restraint was outsourced to the police.

Psychopharmaceutical restraint

Psychopharmaceutical restraint, also known as chemical restraint, occurs when drugs or medications are administered that subdue a person, limit their cognitive functioning, and restrict their freedom of movement (Robins et al., 2021). These medications are defined as beyond what would ordinarily be considered appropriate ‘standard treatment’ for the person (National Disability Rights Network, 2021). However, the presumption that the ‘standard’ is ethical or that there is an agreed-upon standard should also be scrutinised. Psychopharmaceutical restraints are typically administered against a person’s will, including when a person feels compelled to take them or when the person has not been fully informed of the medication’s purpose and effects. In the troubled teen industry, programmes may administer drugs with sedative effects as part of a daily routine, and some will use psychopharmaceutical ‘rapid tranquillisation’ to immediately and temporarily incapacitate a person. These interventions can be imposed on whole student groups or individual students.

Sasha spoke of being on numerous prescription medications, some of which were prescribed to counter the side effects of other medications. She was assigned to a psychiatrist at the school, “I guess well-meaning, but I don’t know what he was meaning because he just put me on so much shit.” She recalled:

“I was on probably three different mood stabilisers and an anti-psychotic and an anti-anxiety/depression thing but a non-SSRI anti-anxiety thing at the same time. ...so, I was on Lithium, Neurontin (brand name Gabapentin) and Depakote (divalproex sodium) until I was old enough, when I was sixteen, to go on Lamictal (brand name Lamotrigine). When I was on those three, the effect of the Lithium was that I had Hypothyroidism, the effect of the Depakote was that my hair really changed... like falling out”.

Sasha was required to take three powerful mood stabilisers simultaneously, despite a lack of medical research evidencing this as safe or effective. In a follow-up email, she sent me a copy of the medications listed in her case notes: Lithium, Depakote, Buspar, Caltrate, Synthroid, Allegra, Singulair, Seroquel, and Lamactil. This combination would not ordinarily be administered, especially to a teenager. The medication interfered with her cognitive processing and ability to function. In the interview, Sasha told me with an exasperated expression, “Meanwhile, I don’t have bipolar disorder, so it was all for nought really.”

While Rachel was in the troubled teen industry hospital ward, she was repeatedly forced to take Chlorpromazine, a powerful antipsychotic medication (Ahmed et al., 2010).

Chlorpromazine (brand name Thorazine) is used “to calm highly agitated individuals experiencing mental disorder who have not responded to non-pharmacological approaches” (Cookson, 2018, p. 346). At a high dose, the medication acts as a rapid sedative that reportedly calms patients and induces drowsiness (Snyder et al., 2021). Rachel described that the medication was so strong that she could not function for a couple of days after it had been administered. She remembered once being forced to take the medication for no apparent reason:

“There was one time when I was actually in the observation room for hours and I wasn’t doing anything, I was just standing there. One of the nurses came to me and said, ‘you have two choices, you can take it by mouth, or you can take the needle’. And I was like, ‘but I’m not doing anything’. He was like, ‘don’t argue with me!’ I think they mixed me up [with another student]. I had to take it by mouth. And that knocks you out, sometimes for a couple of days. So, I don’t even know what happened to me during that time I was knocked out.”

Rachel was tranquilised against her will and without an explanation for why the drug was being administered. The drug was not simply a ‘rapid’ or ‘calming’ intervention; it incapacitated her and disrupted her memory recall. Thorazine was one of several drugs she was put on during her time at the TBS, “they put me on Depakote, Risperdal, Prozac, and Thorazine sometimes, and then Benadryl to knock me out at night.”

Neglectful restraint

There are circumstances in which neglect can act as a form of restraint. What I have termed ‘neglectful restraint’ are actions and inactions that restrict a person’s access to medically necessary care, assistive technologies, or appropriate nutrition, sleep, and living conditions, if these subdue a person or restrict their ability to move, control their body, or leave the premises. There is limited research on this form of restraint, which has largely gone undefined. In the troubled teen industry, denial of basic needs and everyday items can be strategically implemented to make it more difficult for young people to run away or resist treatment. Food and sleep deprivation can be used to interfere with a person’s cognitive functioning as well as their physical and psychological resolve. Purposefully exposing people to extreme temperatures can also restrict a person’s movement and ability to function (Horsburgh, 2004). The withholding of everyday objects to restrict movement, such as removing shoes or an asthma inhaler, create practical obstacles to young people trying to flee (Berzlanovich et al., 2012). Neglect can be utilised as means to coerce compliance and restrict movement.

When Eva was sent to the wilderness programme, she was taken to what she called the “middle of nowhere” and denied access to sufficient nutrition for weeks. She spoke of how there was no “proper food, everything I ate was either from a can or granola for three and a half months.” Students would often go hungry, especially after being forced to hike dozens of miles a day. For Bridgit, when she was on ‘silence vest’, staff took away her shoes and ensured she wore clothes that would be highly visible from long distances. Bridgit described,

“They [TBS staff] took everything away from you. Like your shoes, you had to wear slippers, you had to wear the day glow vest. You couldn’t do

anything alone, you can't shower alone, you can't go to the bathroom alone. It's basically like being on 'suicide watch'."

These measures acted as restraints as they became significant obstacles to their freedom of movement. Neglectful restraint made it difficult for students to run away. For example, running away without shoes or while malnourished would likely cause pain and discomfort, which would slow them down and impede their ability to escape. Even if not held down by physical force or chemically subdued by medication, withholding access to basic necessities could hold students back in different ways. These interventions are especially powerful when multiple forms of restraint are enacted or at threat of being enacted simultaneously.

Seclusion and restraint as everyday violence

The imposition of seclusion and restraint on Sasha, Bridgit, Eva, and Rachel were extraordinary measures undertaken by troubled teen industry facilities as ordinary aspects of daily life. These participants did not experience seclusion and restraint as proportionate responses to imminent risk of serious bodily harm or death. Instead, they recalled that seclusion and restraint were used by TBS for a variety of reasons, from punishment to supposed 'character building'. The measures were always present as a possibility, even when they were not actively enacted on the individual student. These interventions were meant to keep students in line, literally and figuratively. SR became a core aspect of the "everyday violence of aversive technologies" (Adams & Erevelles, 2017, p. 350).

The use of seclusion and restraint was multifaceted and had immediate as well as broader practical and symbolic impacts. SR was sometimes expressly incorporated into institutional life- as part of the privilege level system or as an 'emotional growth' experience. When Eva was confined to a shed on campus, this was ostensibly neither punishment nor crisis response to imminent safety risk. 'Solo' was depicted by the programme as an opportunity, "a time to meditate and self-reflect." Eva explained that students would be compelled to go 'on solo':

"It's 'voluntary', but if you don't do it, you don't get your next [privilege] level and you don't leave, so it's not voluntary. They basically stick you in a shed. I was there for over a week of zero human contact. ...I was literally alone for a week in solitary confinement. ... Not everybody did it, but most people did."

Eva was effectively required to be in confined seclusion for a week if she wanted to progress through the privilege level system. This confinement was not exceptional, *most* people went on 'solo', it was a standard phase of the programme.

The TBS Sasha attended administered sedatives to nearly all the students. Every evening the students were required to take the powerful antipsychotic drug Quetiapine (brand name Seroquel). At the time, the US Food and Drug Administration licensed the drug for treating psychosis and bipolar disorder only (US DOJ, 2010). However, the drug has commonly been used 'off license' in residential care settings to induce sleep (Brett, 2015; National Disability Rights Network, 2021). At the programme Sasha attended, the medication was used to make students drowsy so that they would all fall asleep at the same time. Sasha described,

“We were all pretty much on Seroquel, as not just a sleep aid but as a way to enforce a nine o'clock bedtime. We were all given meds, or maybe it was a ten o'clock bedtime, I don't know, but we were all given meds at the same time. So, we would all take our bedtime meds, and most of us took Seroquel at night even though it's an anti-psychotic.”

Therapeutic boarding school staff administered a powerful anti-psychotic medication to the *majority* of students, even though many of these students were not experiencing 'psychosis' or 'mania' for which the drug had approved usage. This use of medication was not based on what the young people needed, the sedatives were administered as a convenient way to maintain the institution's daily schedule.

Seclusion and restraint were also used to quash resistance and punish noncompliance. At the TBS Bridgit attended, the staff had encouraged students to speak up about issues they were experiencing with the programme. Staff reassured them that it was an opportunity to be open and honest and that students would not be punished. Despite these assurances, when Bridgit told them how she felt, she was demoted to the lowest privilege level and placed on 'silence'. She described expressing her feelings to staff and the swift consequences of having done so,

“I was like, ‘I feel like every day like we're treated like patients, we're not treated like human beings, we're constantly being told we are bad people, you're punishing us all the time for the things that we did without knowing who we are’. I just said everything. Then I immediately got pulled out [of the meeting] and got put in a day glow vest, was put on ‘silence’ from the community. All my privileges were stripped from me. I was told I was a ‘negative leader’.”

This functioned to deter dissent and had an immediate practical effect – literal silencing. Bridgit recalled the conditions of her being on silence, “I could talk to staff, but that was it because they felt that I was going to negatively influence other students of the school.” Students would be prevented from sharing their discontent, therefore social seclusion was used to obstruct peer solidarity.

Seclusion and restraint did not have to be directly applied to the individual; the threat of SR was often sufficiently impactful. In every programme attended by the participants, there was always the risk of being sent to a programme that was seen to be even worse, where even more SR were likely to be used. Sasha explained,

“People were taken pretty frequently into wilderness... it was mainly girls would be pulled out periodically to go to the hospital and boys would be pulled out periodically to go to wilderness. I don't know if it was a collaboration between the school and the parents of these kids or if it was a unilateral decision.”

The risk of being taken to (or by) external agencies acted as a deterrent for students, and also presented potential opportunities for interrelated programme profit. These agencies would often partner with each other, referring students between them, generating income for each other. Forcible transportation, wilderness therapy, hospitals, and therapeutic

boarding schools would often work together. Furthermore, students who went between agencies over an extended period would generate more income for the agencies. For the troubled teen industry, the fees were being paid as long as students stayed. Discipline and pathologisation were financially incentivised. Sasha remembered thinking to herself at the time, “I was just like, ‘what the fuck are you guys doing, like why are you keeping everyone here forever?’ I just felt like I was going to get trapped and stuck. The longer I stayed, the less possible it was that I would leave.”

Where the psychological pressure of SR (or the threat thereof) did not sufficiently coerce cooperation, SR could be used to intervene physically or cognitively and *force* compliance. One form of seclusion and restraint could escalate to a cycle of ever-increasing instances of SR, often escalating in severity. When Rachel was placed in confined seclusion at the hospital, banned from speaking with others, in the cold and without materials to help pass the time, she started to, in her words, go “crazy”. The staff responded to her increasingly distressed and erratic behaviour with even more restrictive forms of confinement, and she was forcibly placed under psychopharmaceutical restraint. She recalled,

“They [hospital staff] started putting me on the [TBS] protocol, where I wasn’t allowed to leave the room. I started going a bit crazy. I was just this young kid, I didn’t have any books, nothing. I was in a hospital gown, I was cold. There were these tiny little hole-y blankets that they gave us. I didn’t have access to anything. I didn’t know where I was going or how long I was going to be there. I would come to the door. I would get antsy or something. Then they would put you in the smaller room, like a tiny observation room, a padded room. Then if you made a big fuss in there, you would get threatened to get shot in the butt with Thorazine. They were like, ‘you can either take Thorazine by mouth or in the butt’.”

The message was for students to behave according to institutional norms, or their situation will only get worse. Here seclusion and restraint enacted the opposite of protection from harm, it was an infliction of harm. SR techniques of social control conditioned young people to show deference to authority. The use of seclusion and restraint did not protect these young people, they protected the interests of the institution.

Coercing conformity

Seclusion and restraint were techniques used to enforce conformity and compliance with the institution’s ethos. SR would act to fuse the undermining of bodily autonomy with epistemic subjugation, a coercive tool to regulate behaviour. While SR could sometimes be clandestine, their use was often described as openly embedded into institutional practice, as if it were ultimately for the benefit of the young person and the community. The institution established itself as the benevolent knower and justified director of what was and was not acceptable behaviour (Chapman & Withers, 2019). Young people’s feelings, wishes, and behaviours were considered problematic and *against their own interests* unless (and, ultimately, until) these appeared to be in congruence with the norms and values of TBS. “In the psychiatric institution, therapeutic interventions are closely linked to disciplinary action because conformity, control, obedience, surveillance and structure are considered beneficial for mentally ill individuals” (Jacob et al., 2018, p. 77). Noncompliance

was treated as pathological, and seclusion and restraint as for the good of the person and the community.

Therapeutic boarding schools would act as the arbiter of good or bad behaviour, healthy or unhealthy ways of thinking, and troubled or respectable self-expression. At the TBS Sasha attended, the programme was geared towards transforming students into middle-class cookie-cutter young people, “the people who work there legislate what a ‘healthy’ subject is, and it is really dressed in like khakis and a polo”. Sasha remembered feeling that the programme did not appear to focus on what she and her peers felt was most important, the TBS had its own agenda that students were coerced to fit into. She said,

“I just don’t think the school cared at all what we wanted. It was only about what they perceived we needed. Which was just really plainly evident in the fact that I was prescribed so much medication that I didn’t need.”

Widespread excessive use of psychopharmaceuticals was one manifestation in how these institutional ideals were regulated. The programme would control what medications she took, what she could eat, and what she could and couldn’t do, lest she risk punishment. Sasha was under constant scrutiny, “I was being watched 100% of the time”. She summarised, “if you exercised more freedom, they punished you with less”. The school’s objective appeared to be to reform to conform.

Young people would be pressured to accept or appear to accept the institution’s narrative of who they were and what they needed. This included the adoption of their therapeutic philosophies. For Bridgit, the TBS would persistently reinforce that she was ‘bad’ and required psychopharmaceutical intervention. She reflected,

“I don’t think the medications were helpful, I think they made me worse. I think I was sold a narrative and told to read certain books that described like a medical model of mental illness that fucked me up for years... I don’t think I should have been prescribed most of the medication I was on. I don’t think I understood what it was, there was no real informed consent that happened before I took those medications”.

Bridgit remembered thinking at the time, “I was like, I’m going to do whatever I have to do, I’m going to say whatever I have to say, be whoever I have to be to get the fuck out of here, cause this is fucked. I quickly realised it was like predominantly Mormon, so I decided I would become like a model patient, and that’s how I was going to get through that.” Where refusal is likely to result in punishment, “some patients may feel like there is no other choice but to submit to biopsychiatric explanations or narratives of distress and treatment in order to be discharged from the hospital” (Pilling et al., 2018, p. 206).

By the time Bridgit arrived at the second TBS, she had already learned to follow the rules and avoid drawing attention to herself. This, however, would also cause problems. She described, “I was pretty reserved, I was just trying to fly under the radar, that was my theory, from the beginning of how to make it through, and so I would get that feedback sometimes, people would ‘call me out’ for being quiet.” The students would be compelled to appear as if they were rule-abiding *and* emotionally participative,

"I think the girls were just going through it to get through it, and it was weird because like the therapist and the people that worked there would kind of like 'call you out' if they thought you were faking. And it's like how are you really, are any of us really being authentic when none of us are here by choice? That was a really weird thing, like the work felt very coercive."

Students had to do more than simply what they were told, they needed to be seen as believing and participating in the programme. There was coercion for compliance as internal feelings and external behaviours.

Seclusion and restraint often lead to a sense of powerlessness for those subjected to it (Scholes et al., 2022). Powerlessness was not just an iatrogenic effect, seclusion and restraint can be used intentionally to demonstrate to young people that the programme's authority has ultimate power over their daily lives. "Seclusion is a form that takes places inside the walls of the psychiatric institution so as to teach a lesson to the disruptive individual and send a straightforward warning to fellow patients" (Jacob et al., 2009, p. 80). Young people could be subject to continuous experiences of SR until they reach a point of submission. Rachel described that when she was in confined seclusion, she had to accept a state of powerlessness:

"It was really hard for me not to have any control. Basically, you have to behave for them to get out of a situation that is so inhumane. It is so demeaning. They're like, 'until you do this and this, you're not coming out of this tiny little room'. It's like, you don't want to behave because you're so mad at them. It created a lot of noise and nonsense."

Rachel was angry and resentful about the inhumane conditions she was forced to endure, but she felt the only way out was to suppress these feelings and show deference to authority. This wearing down through SR can result in "induced docility, reinforcing the need to cooperate with staff" (Jacob et al., 2018, p. 106).

The students who persistently did not comply would be subject to the highest levels of seclusion and restraint. Bridgit observed that these were often students with complex trauma histories, especially young women who were voice hearers. She described that they were the ones who "probably got it the worst",

"I'd seen people be 'on silence' for much longer and usually they were girls that were hearing voices. That's the other thing I noticed is the people with probably either severe trauma or severe mental health issues were punished more than anybody else because no one knew what to do with them. They didn't have the foresight maybe I did at the time to, like, just fucking comply, comply, comply, don't resist ever, don't question anything. They probably got it the worst."

The programmes were described as punishing young people with complex trauma, not supporting them, especially young women. This corresponds with broader research which suggests that trauma victims/survivors are more likely to be subjected to SR in psychiatric settings than their peers (Hammer et al., 2011). In addition, victims/survivors of trauma had

their ways of coping pathologised and intervened with punishments that would likely add to their pre-existing psychological trauma (Scholes et al., 2022).

To cope and survive in this context, all the participants described having felt a need to submit to the programme's rules if they ever wanted to leave. SR created "a persistent state of fear... that these interventions could be used again" (Scholes et al., 2022, p. 382). "This could be described as using physical security in place of relational security encouraging passivity and compliance as indicators or progression through services" (Fish & Hatton, 2017, p. 803). Compliance was interpreted by TBS staff as an indication of student progress, but students experienced it as a suppression of their feelings and needs. This was epistemic silencing by threat. Participants felt dehumanised, as if they were 'not really alive'. Sasha explained,

"I just started to think I'm only learning how to be disciplined, like I'm very disciplined here because I want to leave. I'm doing everything that's asked of me, but I'm not really alive, I'm just following rules."

Where resistance is pathological, coercion is care, and violence becomes help, subservience becomes a marker for success. This presents a quagmire for coping, as previous notions of selfhood and safety are taught as wrong. It can be confusing and overwhelming for students to decipher what *they* believe is in their best interests beyond the institution. This was experienced as traumatic by students.

When abusive living conditions are inescapable, internalising the institution's messages can become a survival tactic (Herman, 2001). Psychologically, the extreme circumstances were more manageable and less overwhelming if Eva adapted to believing the programme was good and that she was the problem. After she was subjected to forcible transportation and wilderness therapy, she became subdued and started to believe in programme doctrine. "I was completely brainwashed," she said. Eva described the situation:

"They basically just completely broke me. Like a horse I was wild, and they broke me until I was completely submissive, you know, 'I'm wrong, I'm wrong'. [Until] I don't feel anything, completely numb."

Once Eva submitted to the programme's expectations, she was transferred back to the TBS. From then on, she became a model student. In her words, "I was the star, I was on top of the world, I immediately went up my [privilege] levels." This was not merely performative; she genuinely perceived the system as a legitimate benevolent authority.

The institution becomes a kind of 'sovereign power' that holds "a particular type of relationship in society, a monopoly over decision making that enables the authority in place to differentiate, exclude, and possibly use 'legitimate' violence" (Jacob & Foth, 2013, p. 182; Agamben, 1998; Christenson, 2017). SR is "a punitive choreography through which the spectacle of discipline is repeatedly inflicted on the patient population and where the power of healthcare professionals is displayed for others to see." (Jacob et al., 2009, p. 79). The "adherence to in-house rules is part of a 'therapeutic' agenda and conformity is documented as a sign of recovery from mental illness... this display of sovereign power raises pressing questions about the very notion of 'disruption' and what constitutes a 'disruptive behaviour'" (Katsiyannis et al., 2019, p. 81). In essence, SR are an enactment and

reinforcement of unequal power relations. In the context of TBS, SR was the practical infliction of epistemic subjugation and silencing. Through the legitimising and normalising language of the therapeutic, SR represented the violent consequences of deviance in the face of compulsory conformity.

Long-term impacts

The ongoing exposure to SR were described as having a profound impact. Sasha explained, “there’s perhaps nothing so formative in my life as having gone there.” For Rachel and Eva, this impact was resolutely negative and traumatising. Rachel spoke of having had “PTSD from this for quite a while”. Eva detailed ongoing post-traumatic symptoms relating to her troubled teen industry experience:

“I’m always hyperalert. I’ve had fears of being sent back to treatment, nightmares of the two ‘goons’ [‘transporters’] coming to kidnap me and throw me into a van. I have weird panic attacks sometimes”.

She spoke of how ‘tarping’ specifically continued to have traumatic impacts on her, “the tarp thing in wilderness really affected me, I can’t be under the blanket entirely when I’m in bed, and I have to keep one foot out on one side because I have to know that there is an exit. If I get somehow caught in the fabric of the blanket, I’ll have a panic attack.”

Bridgit described how TBS installed in her a “prison mindset” that she endured but did not consider herself to be a “survivor” of. At times comparing herself to others, at times normalising extreme conditions, she described how she felt about her time in the programmes,

“I don’t feel like I survived it, I feel like I managed it. It’s like saying you survived jail, it’s like anybody can survive this. That’s how I feel, anybody can manage this, this is manageable. You get to a point where you become so beaten down by the need to be compliant that you realise it’s just something you need to manage in your life from now on. And it’s scary that kind of prisoner mindset was established in me at like sixteen, seventeen ...I forget, I minimise this shit... some of the extreme things have been normalised for me.”

She explained that coming to terms with the TBS experience has been complicated, “it’s hard for me to say like ‘yes that was abusive’ when my definition of abuse is very extreme. I think, absolutely, if nothing else, it reaffirmed a ton of negative beliefs about myself and being a bad person and being wrong and deserving bad stuff to happen to me, I think it really fed into that.”

All the participants expressed a desire for support and less restrictive interventions before the point where their parents felt a need to send them away. Between them, they cited a lack of support for young people and families as a key issue and that this service provision gap was part of what led their families to choose a TBS. A change in social and cultural attitudes was also felt to be important, one that was more empowering for young people, where people expressed their feelings more openly without fear of shame or punishment,

and where young people were allowed to make mistakes and have struggles without being so readily pathologised. For Ciara and Eva, these were specifically related to gendered and sexualised violence, rape and the threat of rape, and the profoundly detrimental impact this had on their emotional development. Ciara wondered what may have happened if she felt safe to talk about her experience of rape as a teenager:

“If I told anybody I was raped, I was going to get questioned, and I was going to get in trouble, that’s what I knew. And maybe if my narrative around that had been a little different, maybe if I thought I would get support and people would meet me where I’m at and I wouldn’t get in trouble, you know? Maybe I would have been more open about it, maybe I would have gotten help sooner before I started smoking meth. So, that’s what I think about it, it [the TTI] exists to fill a need that shouldn’t be there because of the way our society is in general.”

Among the four participants, there was a general conclusion is that there needs to earlier and more ethical options of care for young people and families.

In addition to wishing there had been more support for them as teenagers, there needed to be ethical and consent-based support for people who have been through the TTI. Several participants described having TBS peers who had died from self-killing or drug overdoses. They all spoke of experiences of not being believed about their time in TBS, as well as fear of disbelief. This was especially impactful when family members denied or minimised their experiences. There was also a sense that they, too, had to process what they had been through and recognise the scale and impact of what had happened to them. Rachel described a profound psychological impact of the programme on her sense of reality and her ability to process what she had been through:

“I was really confused because I didn’t know what the reality was. You don’t want to believe that people you just spent the last year, two years, with were bad people. At the same time, you kind of knew that they were. It was like a slow unravelling. Then finally my parents started listening to the stories more and accepting that was the reality, that it was like a cult and that it was abusive.”

Recognising abusive practices from caregivers and learning to cope with the traumatic impact of this was an “unravelling” and, for some, a life-long journey. All four participants had spent years in counselling as adults and expressed difficulty in coming to terms with what had happened to them in the TTI.

Implications for practice

Young people in the troubled teen industry have been subjected to power abuses and torture in the form of seclusion and restraint (Adams & Erevelles, 2017). These were not proportionate or preventative responses to emergencies (International Coalition Against Restraint and Seclusion, 2023; Carlson et al., 2021). They were tools to sanction compliance and cooperation (Jacob et al., 2018; Scholes et al., 2022). The use of seclusion and restraint is more likely to reflect the interests and the culture of the institution than the behaviour or

supposed pathology of the individual. Ultimately, the therapeutic boarding school encapsulates seclusion and restraint: holding young people against their will and under coercive conditions, severely restricting their ability to communicate with the outside world, and confined on remote campuses, they cannot leave without fear of punishment. While specific applications of SR could be reduced or altered, this does not equate to safe or supportive environments. There are several important implications, however, that remain important for practitioners, researchers, and social policymakers to consider.

Trauma responses should not be responded to in punishment, nor should any punishment be carried out under the auspices of a therapeutic environment. SR are likely to increase distress and traumatise or re-traumatise young people. This is especially the case for ‘troubled teens’, many of whom will have prior histories of trauma. Seclusion and restraint can lead to increased resistance, responded to with more severe forms of SR, that become “cycles of trauma and response [which] perpetuate human suffering” (Hammer et al., 2011, p. 574). Bridgit reflected on how young people’s trauma responses were often treated as signs of ‘defiance’ by staff,

“The thing I think people don’t understand is like most 14 to 17-year-olds aren’t going to tell their parents about their trauma, or their legal guardians, whoever that might be. I think most of us like had some crazy PTSD going on. So, yeah, if you come at me, I might freak out ‘cause this is a PTSD reaction, you know. Like when a girl punched somebody or something, now with the knowledge I have, I look back on that and I think about how that might be like more related to trauma than being ‘defiant’ or ‘violent’.”

There is a need for a greater understanding of trauma and its impact on young people and for staff to respond to acute distress with compassion instead of discipline.

Current best practice guidelines suggest that staff need improved training in de-escalation tactics (Slaatto et al., 2021; Goulet et al., 2016). This can include a talk-down approach where staff encourage a person in crisis to talk with them about why they are angry, scared or upset (Fish, 2018; Scholes et al., 2022). There is no singular way to best de-escalate crisis situations. Staff need to get to know people, have compassion for, listen to and respond to the needs of the individual rather than act on assumptions about their needs based on prejudice or proforma. Young people should be listened to and respected with decisions made collaboratively. To build a trusting relationship, staff must show trust towards students before they can expect students’ trust in return. To establish such trust, staff and programmes would have to be worthy of it. This would require consistent ethical and supportive care. In essence, there would need to be a broader institutional “replacement of coercive strategies with collaborative ones” (Masters, 2018, p. 78).

Seclusion and restraint may be necessary in some extreme circumstances, as inaction can be dangerous. At the TBS Sasha attended, she witnessed a student jump to his death, an experience she can only partially remember,

“This kid came in and he was very upset... was like throwing chairs around the nurses’ office and no one really knew... it just seemed like he was

having some kind of tantrum. And then, my memory's really foggy around this, but like five minutes later I think we heard something, then everyone was screaming. I don't remember like the subsequent, like, I don't remember anything really vividly... But he jumped off the building and killed himself."

In these very limited circumstances, the least restrictive form of seclusion and restraint may be an appropriate emergency response. However, there needs to be an ongoing effort to support people under duress before it escalates to such extreme circumstances. This includes addressing abusive, neglectful, and otherwise harmful or inadequate care. A young person should not feel that killing themselves is a better option than living through the programme or other aspects of their life. As per the high rates of post-TBS suicide discussed earlier, immediate physical prevention cannot go on forever. To physically prevent suicide does not enable living.

While not resolving overall institutional problems, the participants did describe instances where individual staff recognised harmful practices and chose to speak out. Bridgit and Rachel had staff members call their parents to advise that they be removed from the programme. Rachel described how a nurse risked her job by acknowledging the abusive institutional conditions,

"The nurses noticed that we were always being locked up and that we were not crazy. One of the nurses finally told my mum, 'I don't think she should be here and she's having a really difficult time. I could lose my job for saying this, but she is not being treated well,' or something like that. That's when my mum decided to transfer me."

This resulted in both students being taken to reportedly less restrictive programmes. These interventions on institutional harm help on an individual level. Still, more must be done to encourage whistleblowing to authorities and for legal actions to function with greater accountability (Tiitinen, 2020).

While seclusion and restraint have overwhelmingly negative outcomes in general, it appears to have an even more severe impact on women, who have reported the experience as dehumanising (Scholes et al., 2022). SR can result in women feeling a sense of worthlessness and violation of self (Scholes et al., 2022; Fish, 2018). When male staff restrain women, this intervention reinforces institutional and gendered hierarchies (Henriksen, 2017). For women with previous experience of abuse, SR can be triggering and retraumatising. "The nature of women's experiences of trauma, emotional expression, relationships and restraint were profoundly different from men's. These gendered experiences are often under-appreciated in the literature about coercive methods. We argue that the use of restraint should be reframed, taking into account gender as well as disability dynamic" (Fish & Hatton, 2017, p. 804). While men are also victims/survivors of child abuse and can have similar emotional responses to SR, the gendered impacts have been under-researched.

Despite disabled students having enhanced protection under the law, they remain one of the groups most likely to be subjected to SR (Katsiyannis et al., 2019). While the situation in some TBS may have changed over time, we currently have minimal assurance that this is the

case beyond the testimony of staff and, in some instances, occasional inspections. While official government advice may *advise* against using seclusion and restraint except as a 'last resort' emergency measure, the *law* is much more permissible and difficult to enforce in the context of private and isolated institutions. News reports uncover ongoing use of seclusion and restraint as routine practices in some TBS (VICE News, 2021; Miller, 2022a; Kelner, 2023b). As Adams and Erevelles aptly ask, "on what grounds are children and young adults diagnosed with intellectual disabilities, mental illness, and autism located outside the pale of protection from the law? And, what ontological assumptions regarding be-ing disabled make these forms of punishment justifiable?" (2017, p. 354).

Conclusion

Seclusion and restraint are used as tools of everyday violence in therapeutic boarding schools, carried out under the auspices of the well-being of young people and the institutional community. SR can be expressly used or be part of a more subtle set of institutional practices. These were interventions based not on emergency crisis response but as routine, standardised, and normalised practices. The programmes would use SR to regulate social behaviour and quash deviance. Deference to authority and compliance with rules was interpreted by staff as a sign of emotional progress. Pathologising and disciplinary tactics may have invoked compliance through fear, but this inflicted profound psychological harm on young people. These interventions were traumatic and dehumanising for the four participants included in this chapter. Rather than as a 'last resort' to protect young people from harm, SR was used to protect the institution's interests with dangerous and harmful consequences for young people.

Chapter nine: Institutional childhood sexual abuse

Introduction

When I began writing this dissertation, I did not intend to have a chapter on institutional child sexual abuse (ICSA). I had planned to discuss it where it emerged as relevant in other chapters, but it was not a key site of my analysis. While writing the chapter on seclusion and restraint, reading and re-reading the case study transcripts, I saw what I have interpreted as a pattern connecting institutional childhood sexual abuse and the use of seclusion and restraint in therapeutic boarding schools (TBS). This opened-up broader questions on how the structure and culture of the troubled teen industry are facilitative of ICSA grooming. There have been known cases of ICSA in TBS over the decades, but there are no academic publications that I am aware of that have focused on this (National Disability Rights Network, 2021; Szalavitz, 2006). Child sexual abuse is a difficult topic to breach, but I felt a moral imperative to 'go there'. ICSA thrives on people looking the other way, on the permissibility of silence, and so I have chosen to do the opposite and make institutional child sexual abuse central to my analysis.

There have been numerous reports and lawsuits on instances of ICSA in the troubled teen industry (Madarang, 2023; National Disability Rights Network, 2021). These accounts describe sexual abuse in a variety of forms: students who have been coerced to divulge graphic information about their sex lives, participate in 'rape re-enactments' in the name of therapy, be subjected to invasive 'medical exams', as well as sexual assault and rape by staff (NBC News, 2021; Miller, 2022b; Fleck, 2021; Beattie, 2020; Stockton, 2022; Gulino, 2021). In some cases, criminal convictions have substantiated these claims (Morris, 2023; Associated Press, 2014; Chartock, 2021; Beattie, 2020). When one student has spoken publicly about experiencing sexual abuse in a programme, more victims/survivors often come forward with similar accounts (Szalavitz, 2011; Miller & Gilbert, 2022b). In some programmes, there are accounts of several decades of sexual abuse from one or more staff members (Fleck, 2021). Typically, child sexual abuse occurs alongside other forms of institutional abuse, such as physical abuse and neglect (National Disability Rights Network, 2021; Milne & Collin-Vézina, 2014). These are not just instances of sexual abuse perpetrated by staff members against students; institutional child sexual abuse relies on programme features that enable staff to carry out and conceal abuse.

This chapter focuses on ways staff-to-student child sexual abuse has occurred within and has been enabled by violent institutional cultures. Under the guise of supporting and protecting vulnerable youth, therapeutic boarding schools have created conditions facilitative to the sexual grooming of students. In this chapter, I will analyse potential ways that seclusion and restraint can be part of ICSA grooming processes. I will also discuss epistemic injustice as a crucial element of grooming teenagers, families, and communities to believe the testimony of staff and discount that of students (Fieller & Loughlin, 2022). This chapter is not an attempt to establish 'facts' about instances of sexual abuse, or the prevalence of ICSA in the troubled teen industry. The chapter is a theoretical interpretation and discussion based on participant accounts, academic literature, government, and charity investigative reports, as well as news articles. The aim is to draw attention to how

institutional child sexual abuse is a system-wide problem in the troubled teen industry.

Background literature

Child sexual abuse is a common experience, 18% of women and 8% of men have reported experience of sexual abuse prior to the age of 18 (Stoltenborgh et al., 2011, p. 84). Research unanimously demonstrates that child sexual abuse (CSA) has devastating lifelong impacts on those who are subject to it, with a multitude of harmful and complex impacts on people's emotional, cognitive, and physical wellbeing (Blakemore et al., 2017; Stige et al., 2020). CSA is associated with some of the highest rates and widest range of post-traumatic symptoms (Halvorsen et al., 2020). Victims/survivors are more likely to experience eating issues, self-harm, substance misuse, and suicidal thoughts. CSA victims/survivors are also more likely to be subject to multiple experiences of abuse throughout their life (Centers for Disease Control and Prevention, 2022). CSA is a fundamental violation of the safety of the child, a violation that has lifelong consequences for victims/survivors. Concerningly, CSA usually occurs undetected and, most often, unreported (Reitsema & Grietens, 2016). This makes it particularly difficult to prevent, intervene, and provide prompt support to child victims/survivors.

Children and young people in residential care have reported exceptionally high rates of CSA compared to those living in the family home, although the research is less clear on the extent to which this discrepancy is a result of abuse during or prior to institutionalisation (Jay et al., 2022). There have been numerous high-profile 'scandals' over the last two decades, with the Boston Globe's uncovering of widespread CSA in the Catholic Church as a prominent example (Boston Globe, 2002; Greer & McLaughlin, 2013). There have been several large-scale public inquiries in countries like the UK, Australia, Canada, and Ireland about the nature and extent of ICSA in specific institutions (with the USA comparably lacking in such inquiries) (Kaufman et al., 2016; Jay et al., 2022; Hamilton, 2017). The government inquiries have concluded CSA had been pervasive within the institutions, occurred over prolonged periods of time, and had devastating long-term impacts on victims/survivors (Wright & Swain, 2018; Zammit et al., 2021). Evidence has shown the disturbing ways powerful individuals and institutions can use their positions to cover up abuse, sometimes for decades (McNeish & Scott, 2018). It has become clear that ICSA is widespread, difficult to identify, and can be facilitated by institutional systems and cultures (Death et al., 2021; Palmer & Feldman, 2017).

Research on child sexual abuse

Research on child sexual abuse comes with a multitude of limitations, namely that most instances of abuse are never made known to public health officials and are never reported to the police (Solberg et al., 2021; McNeish & Scott, 2018). Studies relying on legal or medical records are skewed towards representing rare cases where abuse has been officially reported (Mulvihill, 2022; Zammit et al., 2021; Darling & Hackett, 2020). Studies conducted with victims/survivors are usually limited to participants who knowingly and willingly identify their experience as abuse to researchers (Milne & Collin-Vézina, 2014). Self-report studies tend to reach victims/survivors who have engaged with support services or online victim/survivor communities, as these are the spaces where participant recruitment efforts are concentrated (Halvorsen et al., 2020; Wolf & Nochajski, 2022). Those inside psychiatric

units or seen as too vulnerable are usually excluded from participation due to ethics requirements which presume the research would be too upsetting for this population (Stige et al., 2020; Solberg et al., 2021). Furthermore, studies that have conducted research on perpetrators of CSA have focused on the outliers, those who have been convicted of their offences (Kaufman et al., 2016; Sullivan et al., 2011; Erooga et al., 2020). Research, in particular prevalence estimates and risk profiles, should therefore be understood with these limitations in mind.

Relative to the scale and impact of child sexual abuse, there have been few empirical studies on the topic (Stige et al., 2022; Blakemore et al., 2017). Many studies do not distinguish between abuse experienced in early childhood and that experienced during teenage years, despite important development differences between these age groups (Zammit et al., 2021; Winters & Jeglic, 2022). There are significant differences in how teenagers are targeted for abuse, how they are abused, and who abuses them (Falkenbach et al., 2019; Milne & Collin-Vézina, 2014). I will sometimes refer to ‘children and young people’ as a single category to reflect when studies have not distinguished between age brackets. It is important to note the vast majority of research on CSA is retrospective, with few studies having been conducted with children and young people around the age of which they were abused (Wolf & Nochajski, 2022; London et al., 2008). Consequently, the data predominantly reflects how adult participants have come to understand historic abuse.

Like research on CSA more generally, research on ICSA relies on instances of abuse that are made known to researchers, resulting in a large gap in knowledge (Timmerman & Schreuder, 2014). Furthermore, research on ICSA has often been based on specific contexts and therefore is of limited generalisability. As McNeish and Scott summarise, “despite increased awareness of institutional CSA, there is little accurate information on how much abuse occurs in institutional settings and how many children are victims. Studies attempting to estimate prevalence have used different definitions, and most have focused on abuse within particular institutions (e.g. churches) or jurisdictions (e.g. Australia, Canada), so that findings cannot be reliably generalised or transferred to other contexts” (2018, p. 4). There is concerning little data on ICSA in residential ‘care’ facilities for psychiatrised youth in the USA, even though thousands of young people are confined in these programmes (National Disability Rights Network, 2021). A consistent finding throughout child sexual abuse research is that much more research is needed to understand the scale and complexity of CSA.

Disclosure and child sexual abuse

It is estimated that more than half of victims/survivors of CSA do not tell anyone about the abuse until they are in adulthood (Reitsema & Grietens, 2016; Winters & Jeglic, 2017). On average, it takes victims/survivors of CSA between 17 to 21 years before they tell someone about the abuse (Halvorsen et al., 2020). Most victims/survivors never disclose CSA to public health services, and the teenagers who do disclose the abuse are most likely to tell a friend (Solberg et al., 2021; London et al., 2008). There is a wide range of reasons why victims/survivors may struggle to disclose, including guilt and self-blame, confusion about the nature of their experience, the impact of trauma on memory recall, fear of reprisals, social stigma, protecting other people (sometimes including the abuser), and the risk of not being believed (Halvorsen et al., 2020; McNeish & Scott, 2018). The concept of ‘disclosure’ is

often narrowly conceptualised as an act of overt and purposeful telling. Stiege et al. suggest a reconceptualisation of disclosure, “from being viewed as a discrete one-time event, to a relational process unfolding over time” (Stiege et al., 2022, p. 2). Abuse may be unintentionally disclosed, disclosed over time in subtle hints, or communicated through behavioural and emotional changes. Disclosure is interactional and requires opportunities to be heard as much as it does the courage to speak.

The likelihood of disclosure reflects the victims'/survivors' internal processes and their relationships with others around them (Milne & Collin-Vézina, 2014). Most CSA victims/survivors are abused by someone they know- a family member, friend, spiritual or community leader, or person in authority (Bryce, 2020). Adult perpetrators who are well-liked or of high status in communities are often able to successfully deny allegations of sexual abuse. Children and young people are perceptive to this and will assess the likelihood that they will be believed and supported (Reitsema & Grietens, 2016). The victim/survivor may ‘test’ those around them by gauging other people’s responses to subtle references to abuse. The decision not to disclose can be self-protective in the face of overwhelming uncertainty and risk to safety (Halvorsen et al., 2020). This is especially the case where the adult is someone whom a child/young person is reliant on for necessities like food and shelter, or where the victim/survivor has been threatened. Victims/survivors may cope by blocking out the memory of abuse, blaming themselves for the abuse, or finding ways to normalise or excuse adults' abusive behaviours (Wolf & Nochajski, 2022; Joyanna, 2013).

Children and young people may struggle to understand and identify their experiences of sexual abuse (Stiege et al., 2022). A lack of sex education, cultural taboos on discussing sex, and broader societal attitudes on consent and bodily autonomy, can make it difficult to understand what healthy interaction is and what is abusive. It may be unclear to the victim/survivor that what they have experienced is sexual abuse, especially if the abuse was not rape, and if the victim/survivor did not overtly resist (Halvorsen et al., 2020). Perpetrators of CSA are aware of this and can manipulate a victim/survivor into believing the abuse is normal or acceptable (Craven et al., 2007). These interpretive difficulties are related to, and sometimes a part of, psychological coping mechanisms and age-related phases of cognitive development (Bryce, 2020).

Victims/survivors often cope with the violence and betrayal of CSA through dissociation that interrupts ordinary memory recall (McNeish & Scott, 2018). Some experience dissociative amnesia, a temporary or permanent inability to recall a traumatic event or series of events, and/or childhood autobiographical memory loss, where there is a total inability to recall large periods of one’s childhood- such as an entire year of the life course (Wolf & Nochajski, 2022). The repression of traumatic memories is more likely to occur for victims/survivors who are younger, have a trusting or inescapable relationship with the perpetrator, and where there was the use of physical violence or threats of violence. Some victims/survivors later recall (‘recover’) the memories through flashbacks, these can be distinct and intact memories or a more ambiguous ‘fuzzy’, ‘hazy’, fragmented, or distorted form of memory (Stiege et al., 2020; Herman, 2001). The body can also ‘speak’ as memory, through otherwise unexplained somatic feelings and sensations, as well as through bodily response to triggers (Stiege et al., 2020). It can be years or decades until a person ‘uncovers’ these memories, for

some this may be a lifelong continuous process, and some may never recall the events at all.

Method

In this chapter, unlike previous substantive chapters, the analysis will not be presented as case studies. This was due to two reasons: to include a broader range of ICSA experiences and perspectives and to ensure an extra layer of anonymity for this highly sensitive topic. Importantly, I have included experiences I consider to be child sexual abuse, but that were not described as such by participants. I respect that everyone copes with and interprets what they have been through differently. I also believe it is important for researchers not to exclude these experiences from analysis, as how people process and label their experience is important. Most interview participants did *not* refer to having been directly subjected to institutional child sexual abuse. However, most interview participants did describe an awareness or suspicion that sexual abuse occurred while they attended the TBS. These were based on what participants saw in the programmes as well as accounts and 'rumours' they have since heard.

The focus of this chapter is not to establish a factual account of events; it is not possible for me to definitively conclude if or when ICSA occurred. ICSA is an industry-wide issue, and it is likely that sexual abuse has occurred over the course of decades in therapeutic boarding schools across the country. I have sought to analyse institutional cultures that could be seen to facilitate such abuse. From pre-existing research, many perpetrators of ICSA direct sexual violence towards one or only a few individuals within an institution at any given point (Timmerman & Schreuder, 2014). Therefore, most children and young people in an institution where ICSA is occurring do *not* have acts of sexual violence directed towards them, even though such violence was happening to peers at the time. Equally, given the complexities of disclosure and traumatic memory processing, not disclosing ICSA is not the same as not having experienced it. A lack of awareness of ICSA having occurred is not tantamount to an institution free of ICSA.

Definitions

Child sexual abuse

Child sexual abuse can be challenging to define, as can be seen by the various legal definitions in place across US states and worldwide (Child Welfare Information Gateway, 2019; Mathews & Collin-Vézina, 2019). I adopt the Centers for Disease Control's definition of child sexual abuse as the involvement of a child (persons under the age of 18) in sexual acts that they do not consent to, are coerced into or are developmentally unable to comprehend and give informed consent to (Centers for Disease Control and Prevention, 2022). In this chapter, I focus on adult-to-child sexual abuse, not peer-to-peer sexual abuse (although the latter is also important). This includes adult-to-child sexual touch (including, but not limited to, rape), coercing a child to perform sexual acts, coercing them to watch sex acts or sexually explicit material, exposing genitals to a child, recording or distributing sexual images of children, sex trafficking, as well as other forms of sexual violence and exploitation.

Institutional child sexual abuse

Institutional child sexual abuse has been defined as “the sexual abuse of a child (under 18 years of age) by an adult who works with him or her. The perpetrator may be employed in a paid or voluntary capacity; in the public, voluntary, or private sector; in a residential or non-residential setting; and may work either directly with children or in an ancillary role” (Gallagher, 2000, p. 797). In the context of the troubled teen industry, I consider all forms of sexual acts by staff towards students as institutional child sexual abuse, even if the young person is 18 or older at the point of the abuse or is no longer a student in the programme. Grooming behaviours leading up to such abuse are likely to have occurred while the victim/survivor was an underage resident of the programme. The totalistic power of institutional authority and the professional helping status of staff is such that I consider all forms of sexual activity between staff and students (former or current) to be institutional child sexual abuse, regardless of whether the young person is said to have consented.

Grooming

I use the term ‘grooming’ to describe behaviours and strategies used to manipulate a child and the people and environments significant to a child, with the aim to sexually abuse the child as well as to sustain and conceal abuse (Timmerman & Schreuder, 2014; O’Leary et al., 2017). Grooming strategies can include isolating a child, creating a sense of fear, fostering a sense of shame, convincing a child that they are ‘special’, or blaming a victim/survivor for the abuse (Craven et al., 2006). Grooming also includes manipulative tactics to ensure trust (or collusion) from other adults who would ordinarily be expected to protect a child (Raine & Kent, 2019; Sullivan & Quayle, 2012). Grooming is generally understood as conscious and purposeful acts or strategies undertaken for the purposes of sexually abusing children (Winters & Jeglic, 2022). A wide range of behaviours can be forms of grooming, as seemingly ordinary interactions can be subtle tactics to create the conditions an abusive person seeks (Timmerman & Schreuder, 2014; Palmer & Feldman, 2017).

Sexual grooming in therapeutic boarding schools

Child sexual abuse in institutional settings does not take place as an isolated incident or series of incidents inflicted by one person onto another. Institutional child sexual abuse is more than sexual abuse that occurs inside institutions; it is sexual abuse perpetrated *through* institutions. “Institutional grooming involves perpetrators using features unique to the organisational setting to sexually abuse a child. These features include opportunity, anonymity, secrecy, trust, and power” (O’Leary et al., 2017, p. 11). Institutional grooming involves the use of authority and professional status to manipulate the young person, the people who could be a source of safety for them, and the structure of an institution (McAlinden, 2013). For adults seeking to sexually abuse youth, working for the troubled teen industry would grant them access to isolated and vulnerable young people who are unlikely to be able to resist or report their abuse.

‘Professional perpetrators’, a term coined by Sullivan and Beech, are “professionals who use their work as a cover for targeting and sexually abusing children” (2002, p. 153).

Professional perpetrators may purposefully seek employment in organisational contexts to facilitate access to children (McAlinden, 2013). They may also be professionals who did not enter the profession with the intent to abuse but, while working in close proximity to

children/young people, discover, and act on, a 'latent' desire to sexually abuse them (Palmer & Feldman, 2017). This could be a single abuser within a programme who manipulates institutional features. The professional perpetrator can also be at the top of the institutional hierarchy and have the power to design a programme and write the rules (Morris, 2023; Chartock, 2021; Death, 2015). Therefore, the professional perpetrator may be exploiting pre-existing rules and structures for abuse, or they may have designed the structures to maximise abuse opportunities.

The Sexual Grooming Model

The Stages of Sexual Grooming Model (SGM) describes behaviours and strategies CSA perpetrators may use to "gain initial cooperation of the victim, decrease the likelihood of discovery, and increase the likelihood of future sexual contact" (Winters et al., 2020, p. 856). The model suggests a series of stages perpetrators use to gradually increase their opportunities to sexually abuse and decrease their potential to get caught. The Sexual Grooming Model by Winters and Jeglic (2022, p. 25) outlines five grooming stages:

- Victim selection
- Gaining access and isolating the minor
- Developing trust
- Desensitisation to touch and sexual content
- Post-abuse maintenance

These stages are not necessarily linear and discrete grooming processes, some strategies may occur simultaneously, and some behaviours could be classified under more than one category. Perpetrators may revert to earlier stages to increase trust, for example, if they sense a young person's resistance. Sexual grooming does not require all these stages, and some forms of grooming may not 'fit' the model. The SGM should be understood as a tool to help identify and understand CSA grooming, but it is not a definitive guide to what does and does not constitute grooming.

Several models of child sexual abuse grooming have been suggested by researchers (Sullivan & Quayle, 2012; Craven et al., 2006; Elliott, 2017; Ward & Hudson, 2001). Due to the practical and ethical difficulties of researching the subject, CSA grooming models are theoretical and lack empirical validation. I chose to focus on the SGM because it is commonly cited, has integrated prior literature and aspects of other models, and research involving an 'expert review survey' found professionals supported the model's overall accuracy (Winters & Jeglic, 2022). The SGM is also practically-oriented and seeks to bring awareness of grooming behaviours "that could be observable to others and measured" (Winters et al., 2020, p. 860). This model has focused on the individual level- examining the role of grooming in child sexual abuse by an adult towards a child. I have built on the model to analyse how a whole industry can enact and enable these grooming stages.

Therapeutic boarding schools can be structurally and culturally facilitative of these stages, be it unwittingly or by intentional design. The programmes create conditions where perpetrators can readily 'prey' on 'troubled teens' who are under the near total control of institutional authorities. I have drawn on SGM as a helpful resource that describes behaviours and strategies used by perpetrators. I have adapted the order in which I describe

the stages. Many of these ‘stages’ are likely to have occurred throughout the grooming process and not as a distinct phase of strategic behaviour. I consider the victim selection stage as the general targeting of young people labelled as ‘troubled teens’, a structurally disempowered and vulnerable population. Trust building is described in relation to the professional perpetrator’s veneer as an expert helper. I have interpreted the use of seclusion as access opportunities to abuse and isolate the victim/survivor from others. Restraint has been analysed as a means for staff to desensitise young people to non-consensual touch and to demonstrate staff power over young people’s bodies. Lastly, I describe the denigration of ‘troubled teens’ as a powerful way to erode the perceived credibility of young people, sow distrust, and maintain abuse.

This is not a comprehensive list of grooming strategies that could be used in TBS. This chapter seeks to highlight several important elements of institutional grooming within the industry, with a focus on seclusion, restraint, and epistemic injustice. As there have been no academic studies of ICSA in the troubled teen industry, it is not known what (or if) common grooming strategies take place. For example, ‘privilege levels’ could be used to incentivise students, rewarding victims/survivors with greater access to ‘privileges’ if they comply with the sexual advances of staff. Staff may give ‘special attention’ and provide affection to young people who have histories of neglect and rejection (Palmer & Feldman, 2017). The risk of severe punishment, physical violence, and other forms of abuse and maltreatment also act as powerful deterrents to resisting or disclosing abuse (Milne & Collin-Vézina, 2014). The possibilities are relatively endless, as any behaviour becomes ‘grooming’ if carried out by staff with manipulative intent to sexually abuse students (Winters & Jeglic, 2022). The endlessness of behaviours potentially being ‘grooming’ raises a necessary caution: ordinary and healthy adult-child interactions can be interpreted as grooming. It can be difficult to differentiate without the expressed intentions of perpetrators being made known. Therefore, some of the interactions I have raised as a potential indication of grooming will not have been enacted for this purpose nor will they have led to CSA.

Victim selection and the ‘troubled teen’

All organisations that work with children have the risk potential to be exploited by perpetrators of CSA seeking to access young people (Palmer & Feldman, 2017). This risk is amplified in the troubled teen industry by the vulnerabilities of the young people, the vulnerability of their families, and the institutional vulnerabilities that can make youth-serving organisations high-risk environments for sexual abuse (Death, 2015; National Disability Rights Network, 2021). ‘Troubled teens’ are admitted to TTI programmes because, at least in part, they have a history of (real or perceived) psychological and behavioural problems. As was discussed in the questionnaire results chapter, many of these young people have already experienced one or more forms of abuse before entering a TBS. Many will have struggled with low self-esteem, as is often true of teenagers, but this is likely to be amplified for the ‘troubled teen’. Winters et al. describe how perpetrators target young people with “emotional or psychological needs (e.g., child who is perceived as trusting, lacking self-esteem, isolative, neglected, *troubled* [emphasis added], or in need of affection)” (2020, p. 860). In addition, young and psychiatrised people can be denied access to human rights and have this deemed by adults as necessary and appropriate.

Winters and Jeglic suggest that perpetrators will also seek to identify situations where parents are more likely to grant unsupervised access to their children (2022). A family that has handed over their child to a TTI programme has demonstrated their willingness to grant such access. Many 'troubled teens' have fraught relationships with their parents, so a pre-established breakdown in trust may erode the parents' protective capabilities. A parent whose teenager has been experiencing significant psychological or behavioural difficulties may be scared, anxious, or stressed and look to professionals to assist in the care of their child (Klein, 2021; Rouse, 2022). A fearful or overwhelmed parent may be easier to manipulate into developing a trusting relationship with a professional and enrol their child in a sparsely regulated and experimental residential programme. Furthermore, there are 'troubled teens' who have abusive parents who do not show intention to protect children from ongoing abusive experiences, as well as young people who do not have stable and consistent guardians (Morris, 2023). Perpetrators may target vulnerable children as well as vulnerable families, Wolf and Pruitt explain that abusers target 'vulnerable families', "thus reducing the likelihood that a victim will disclose out of fear they will not be believed or that they will be blamed" (2019, p. 348).

The psychological and social position of 'troubled teens', as members of a social group and as individuals, marks them as potential targets. The troubled teen industry generates what McAlinden refers to as "a captive vulnerable population for abusers" (2013, p. 160). A participant explained her understanding of TBS staff who sought to work with young people with histories of having been sexually abused:

"Unfortunately, those sickos go into jobs where they feel they can take advantage of those that need their help. So why not go work with teenagers that have been raped and hope that you can just rape them again and they will be okay. [Sarcastically] 'You already had it once, so does it make a difference?'"

This participant describes how the social workers at her programme, one of whom was decades later found guilty of sexual abuse, likely chose the profession to access young people for the purpose of raping them. Perpetrators targeted the industry for vulnerable young people and the most vulnerable people within that institution.

In addition to seeking to exploit multi-layered vulnerability, perpetrators of CSA may target pathologised and disabled children/young people as those whom they see as having diminished humanity (Clare, 1999; Brown, 2017; Craven et al., 2006). Her quote raises ways abusers may engage in 'self-grooming'- a psychological process where perpetrators find ways to justify their abusive behaviour, principally through "denial or minimisation about the inappropriateness of their behaviour" (McAlinden, 2013, p. 167). Perpetrators of ICSA may devalue the lives of 'troubled teens', deny, or minimise the harm that sexually abusing pathologised young people (Litchman, 2022). The participant believed abusive staff had justified raping students with prior histories of sexual abuse because these staff members saw such abuse as of little significance to the victim ("does it make a difference?"). In a society that dehumanises disabled and pathologised young people, the perpetrator may justify their abusive behaviour *to themselves* as a lesser-offence or non-offence.

“Disabled activists have long discussed the presumption of incompetence as a prevailing theme in the lives of people with disabilities, particularly mental disabilities. The presumption of incompetence conceptualises disabled people as incapable of thinking, feeling, remembering, or deciding” (Brown, 2017, p. 167).

ICSA perpetrators may groom themselves into believing this population deserves to be abused, cannot fully comprehend, or be affected by abuse, or that the abuse is ultimately in the best interests of the child/young person (e.g., supposed sexual liberation or the ‘corrective rape’ of LGBTQ+ people) (McAlinden, 2006; Doan-Minh, 2019; Elliott, 2017; Litchman, 2022).

Within the programme, staff members who sexually abuse students are likely to target specific students (Winters & Jeglic, 2022; Martschuk et al., 2018). This reduces the likelihood of the perpetrator being caught. For example, if abuse allegations become public, other students may deny sexual abuse occurred in the programme on the basis that they did not personally experience it and were not aware of the abuse. Targeted abuse can also contribute to a young person’s isolation from peers. Children and young people can be targeted based on perceived susceptibility to sexual abuse and characteristics seen as desirable to a perpetrator (i.e., gender, physical appearance) (Zammit et al., 2021; Timmerman & Schreuder, 2014). Younger students and LGBTQ+ people are at heightened risk of targeted ICSA, partially because these populations are more likely to be situationally vulnerable (Xu & Zheng, 2015). Gender disparities of institutional child sexual abuse vary, with some suggesting girls are more likely to abuse, and others suggesting boys are, more yet stating it is difficult to conclude as women may be more likely to report ICSA (McNeish & Scott, 2018; Milne & Collin-Vézina, 2014; Death et al., 2021; Smidt et al., 2021). The data is yet to be established in relation to trans and non-binary victims/survivors of ICSA. It is also important to note that male and female staff, heterosexual or LGBTQ+, can sexually abuse young people of any gender (Darling & Hackett, 2020).

Professional status and trust building

The professional perpetrator has likely cultivated a reputation as an esteemed member of the community (Erooga et al., 2020). They are often charismatic, charming, and likeable. They lean on their professional status to establish themselves as trustworthy and credible helpers (Mulvihill, 2022). “In this stage, the perpetrator works to gain the trust and compliance of the minor and significant adults in their lives (e.g., caretakers, community members)” (Winters & Jeglic, 2022, p. 25). Perpetrators can use the trust of professional authority to persuade victims/survivors and those around them that the abuse is acceptable behaviour or is being imposed in a caring capacity. One participant recalled a staff member had been ‘dating’ a student, but, at the time, the participant did not recognise this as cause for concern, “he was dating a student, and I think it didn't really register to me at the time what that meant”. The abuse had been normalised. Trust shields professional perpetrators from suspicion about their access to and treatment of young people.

Therapeutic boarding school staff can operate under the premise of a benevolent helper who is seen to act with expert insight and the best intentions for the welfare of children and youth. This disarms potentially protective adults, such as family and community members,

to perceive otherwise suspicious or unacceptable interactions as acceptable (McAlinden, 2006; Raine & Kent, 2019). Staff 'tough love' towards students comes to be seen as acts of caring, for example. The professional status (licensed or unlicensed) of TBS staff affords the power to write the official record of what happens in the programmes and what students' needs are. One participant described that her parents were very trusting of healthcare professionals:

"Once you're in you're actually kind of stuck until they want you to leave because, and I know that my mom had this in her conscience, of like not doing something against medical advice. So, I was really at the mercy of their [TBS staff] recommendation that I was okay to leave. It was a more subtly distributed threat of 'we're in control of your future'."

The establishment of trust becomes a form of power and control (Death, 2015). Once they have gained the confidence of parents and community members, staff hold powers of persuasion and often determine the length of stay and student's official outcomes.

The language of therapy can be corrupted by staff to sexually abuse students under the auspices of a healing process (Zammit et al., 2021). A journalist described a TTI programme where "systematic sexual and emotional abuse that was carried out under the guise of treatment and endured by students" (Szalavitz, 2011). One participant spoke about a staff member who had been arrested for sexual abuse:

"After I left, he was arrested for three counts of sexual assault and rape of a student. The student had previous sexual trauma and, you know, [he told her] 'If you were really over your trauma and it really didn't bother you, you'd have sex with me'. Complete abuse of power. He was a social worker, unfortunately."

This "complete abuse of power", as she aptly described it, demonstrates that their authority over the narrative can lead to authority over the bodies of young people. Abusive staff can groom families, communities, and 'troubled teens' themselves, to accept them as the authority on the needs of their students (McAlinden, 2006).

All forms of sexual abuse within institutions can be traumatic and difficult to report, but the power dynamics of staff-to-student abuse have specific barriers and implications. One interview participant had experienced sexual abuse from a male peer and a male staff member while in the TBS. He felt able to report abuse by another student (whom there was also more explicit evidence against), but he felt powerless to report the abuse from the counsellor. The former student explained:

"In some ways, it was easier to report the student than the counsellor... it was easier to leverage my own power against him [the student] than it was the counsellor."

The participant was able to comprehend these experiences as sexual abuse at the time, and did not describe having placed trust in the staff member. Instead, he had come to believe he was powerless to change the situation. A young person who is unable to remove themselves from the abusive situation/programme (practically and, if a minor, legally) does not need to

personally trust staff; they need to instead perceive themselves as lacking the power to prevent or safely report abuse (Reitsema & Grietens, 2016; Solberg et al., 2021; Herman, 2001; Halvorsen et al., 2020).

Seclusion and access to minors

Seclusion and restraint can be utilised by ICSA perpetrators to isolate a young person from peers and other staff. “Once they have access to the minor, the perpetrator often tries to separate the minor from peers and caretaking adults so that they can begin the grooming process in private” (Winters & Jeglic, 2022, p. 25). The TBS student is ordinarily cut off from communication with the outside world or has such communication restricted and monitored, yet further seclusion practices can make this extreme situation even more extreme. This pertains to physical isolation that enables a perpetrator to commit acts of abuse with little likelihood of being witnessed, as well as social isolation that distances a young person from supportive and potentially protective peers and non-abusive adults (O’Leary et al., 2017). In therapeutic boarding schools, confined seclusion and social seclusion are formal institutional regulations that intentionally isolate a student from others (Chatfield, 2019). A young person who is locked in an isolation shack or who has lost the ‘privilege’ to communicate with peers is placed under readily exploitable conditions by staff who may seek to sexually abuse them. When seclusion is normalised as an everyday institutional practice, staff members can target and isolate individual teenagers without raising suspicion.

At a TBS with a seclusion measure known as ‘safety’, students had restricted contact with peers and constant supervision from a member of staff. Seclusion facilitated the opportunity for abusive staff to access young people alone and acted as a barrier to young people having the ability to disclose abuse (Zammit et al., 2021). The more a student tried to resist, the harsher the restrictive measures would become. Seclusion was used to cover up instances of sexual abuse as well as to force the student into having ongoing contact with the abusive staff member. An interview participant recalled how seclusion was used to silence a peer who had disclosed sexual abuse from a staff member:

“I had another friend who was being sexually assaulted by a staff member, a female staff member, and they claimed that it was because she was gay and was ‘asking for it’ and ‘it didn’t really happen’, and then they told her ‘if you talk to anybody or say anything, we’re going to drop you immediately to ‘safety’, where she has to be within five feet of staff at all times, so she can’t tell anybody. That they’re going to cut off all her phone communication and tell her parents that she was misbehaving, and that’s why they can’t talk to her. Which they did, and they dropped her to ‘safety’ with the staff member that was molesting her. So, they basically told her, ‘Well, now you have to be within five feet of the staff member that you’re telling us is molesting you.’”

This disturbing example highlights how the language of safety can be used by staff to cover up acts of sexual abuse. The quote also highlights how young people can become specific targets, including LGBTQ+ students, who are more likely to be subject to CSA than their peers (Smidt et al., 2021; Xu & Zheng, 2015). In this instance, the young person was blamed for the abuse on the grounds of their sexual orientation.

Restraint and desensitisation to physical touch

One of the most widely recognised forms of sexual grooming is the gradual introduction of increasingly invasive levels of touch (Martschuk et al., 2018; Raine & Kent, 2019). “The child molester escalates physical contact to prepare the child for the sexual contact that will occur during the impending abuse. Often times this begins with seemingly accidental touch or innocent behaviours, which then escalate to more intimate touching” (Winters & Jeglic, 2017, p. 726). These have usually been described in the literature as forms of “intimate and affectionate” (Palmer & Feldman, 2017, p. 27) touch, but these could also be intimate and forceful. Under the auspices of therapeutic need and protection from harm, physical restraints subject ‘troubled teens’ to potentially increasingly intrusive and violent physical contact. Psychopharmaceutical restraints can also be used to desensitise young people through chemically induced cognitive disinhibition (Hartley et al., 2013). Both physical and psychopharmaceutical restraints exert institutional authority over the bodily autonomy of ‘troubled teens’.

Several researchers have highlighted how physical restraints are more likely to be inflicted on victims/survivors of child sexual abuse (Roy et al., 2021; Hammer et al., 2011), but I have not been able to locate any research on how restraint could be used as a tool for ICSA. I suggest restraint offers staff an institutionally sanctioned form of physical intrusion on the bodies of young people, a pretence that can be used in the grooming process. “Sex offenders, if they are to avoid suspicion, need to find ways in which they can legitimately have contact with children and acquire power over them” (McAlinden, 2006, p. 348). Physical restraints may start as less invasive and gradually escalate in severity, but there is also the potential for rapid escalation of intimate bodily contact. Physical restraints allow abusive staff members to introduce ‘accidental’ touch, such as groping and other forms of sexual abuse, whilst the person is held in the restraint (Miller et al., 2022). Physical restraints could also form part of the act of sexual abuse, such as mechanical restraints that restrict a person’s ability to physically flee the abusive situation. When physical holds, and mechanical restraints are normalised, victims/survivors and whole therapeutic communities become desensitised to acts of forced physical touch.

Restraints can be imposed on students for a variety of reasons, but the psychologising of forced physical touch creates a dangerous pretence for other forms of invasive touch (Timmerman & Schreuder, 2014; Zammit et al., 2021). A former student described that a student with a prior history of sexual abuse would frequently be subjected to restraints at the TBS:

“They [staff] didn't know how to address trauma. Trauma was a big one that they could not get. I had a friend with severe, she had C-PTSD, and she had a severe, um, flashback, whatever, situation and their response to her flashbacks was to put her in a hold. When her CPTSD is from sexual abuse, they decided to hold her down would be the best response. ...Like physically on top of them. Which for somebody who's having flashbacks of sexual assault, not a very good idea! And they would claim everything was, ‘she was going to hurt herself’. No, she wasn't; she needed to be talked to, not assaulted, you know.”

Rather than providing trauma-informed care, the staff enacted trauma-targeted harm that exacerbated the young person's distress (Fish & Hatton, 2017). The harm was normalised by staff as a protective response, despite the psychological consequences of forcefully holding down a sexual assault victim/survivor. The young person was also blamed for incidents of physical restraint, reinforcing a culture of victim blaming (Zammit et al., 2021). However, it is unclear if this student was ever subject to ICSA while in the programme.

Psychopharmaceutical restraints can cognitively disinhibit young people to invasive touch and abuse. Powerful psychopharmaceutical drugs can impact a variety of cognitive, psychological, and physical senses and consequentially impede a person's ability to comprehend or resist sexual abuse (Vander Ven et al., 2018). Tranquillisers and sedatives, for example, are often used to induce drowsiness and can interfere with a person's state of consciousness and cause temporary memory loss (Fabris, 2011; Muir-Cochrane et al., 2020). Drug-induced inability to recall events, especially if used in conjunction with confined seclusion, creates a profound situational vulnerability. The use of psychopharmaceutical restraints, like physical restraints, is an act of institutional power over the bodies of young people. Young people can be coerced into taking medication, supposedly for their health and well-being, often with little regard for the student's wishes.

The coercive use of psychopharmaceuticals creates a premise where non-consensual or forced medical treatments are normalised aspects of institutional life (Mulvihill, 2022). When one participant was in a TBS, she was frequently taken to visit doctors to investigate various health concerns. Her caseworker would drive her there and attend the appointments with the student. The participant is asthmatic, and on one occasion, she was taken to an appointment with a pulmonologist, a doctor who specialises in respiratory conditions. The respiratory expert removed her underwear. In the interview, she did not describe this as abuse; she referred to it as "weird" and confusing. She discussed the experience with me, as quoted verbatim from the interview transcript:

Participant: So, they took me to all kinds of doctors, whatever. I even remember going to a pulmonologist once 'cause I had asthma, and I remember the pulmonologist like pulling down my underwear, and I was just like, you know, it's the doctors, so you're like, 'well I trust them... but, why?' And then I thought, well, maybe like they put something in the notes or something, maybe they thought something was really weird with me. I don't know. Um, I can't really connect those thoughts, but it was weird, and I felt like very under the microscope, of, um, uh, doctors at that point and like... [pauses]

Sarah: Was there someone else in the room with you when that happened?

Participant: Yes. I think [TBS caseworker], or whoever took me. Yeah, and I was just on way too many medications. My body was not mine; it just wasn't. I was not able to control whatsoever what went into it.

In the interview, the participant described how medicalisation had conditioned her to feel that her body belonged not to herself but to professional authorities. She had trusted the doctor, and the TBS staff member who had taken her there, and this impacted how she

interpreted what happened. Speaking with me more than a decade after this occurred, her interview reflects the complexity of coming to terms with ICSA perpetrated under the auspices of treatment by medical authorities.

Institutional child sexual abuse can occur outside the confines of the institutional facility, including by persons external to the organisation. Although the research is limited, it appears children and young people in residential care are at risk of sexual abuse from staff working within the institution as well as external to it (Barker & Place, 2013; Allroggen et al., 2017). Such abuse may be knowingly facilitated by staff who collude in the abuse or be the result of outsiders targeting young people with ‘troubled’ backgrounds. In particular, journalists have uncovered hundreds of accusations of sexual assault from medical doctors towards patients, and the premise of medical examinations appears to be a common form of deception (Erooga et al., 2020; Teegardin & Norder, 2019; Mulvihill, 2022). Note these supposed examinations can also be imposed by TBS staff, including those with no license to practice medicine (Stockton, 2022). These occur in a context where young people have been conditioned to accept, and potentially not even question, bodily intrusion and harm if carried out by trusted professionals and those in positions of power.

Pathologisation and post-abuse maintenance

Perpetrators of ICSA may purposefully and publicly denigrate the credibility of those they abuse. The pathologised young person is especially vulnerable to this form of manipulation, as young people and pathologised people are, by default, seen as having diminished credibility in our society (Brown, 2017). In the troubled teen industry, staff routinely stigmatise and degrade young people in their care (Miller, 2022b). This helps to ensure that young people are seen as unbelievable and as troublemakers in the eyes of those around them. This protects abusers in the eventuality of abuse accusations and further the victim/survivor’s social isolation (Mulvihill, 2022; O’Leary et al., 2017). Young people, as well as non-abusive staff members, may come to believe (often accurately) that they would not be believed and therefore decide not to disclose abuse (Reitsema & Grietens, 2016; Lockitch et al., 2022). Debasing the perspectives of young people deters abuse disclosure, encourages disbelief and shaming of those who do disclose, and sustains a culture of silencing (Raine & Kent, 2019; Sullivan & Quayle, 2012). The distrust of children/young people, in tandem with the enhanced trust of the professional, enables abusers to act with a greater likelihood of impunity and to sustain their opportunities to abuse.

Professional perpetrators may create opportunities to shame and demean victims/survivors within the TBS community (Wolf & Pruitt, 2019; Zammit et al., 2021). The institutional culture that is permissive to staff committing sexual abuse under the guise of therapy can also degrade young people and call it ‘emotional growth’ and ‘group therapy’, as described by one journalist:

“Several girls reported being called sexually shaming names while made to perform various sexualised routines during ‘emotional-growth seminars,’ called Lifesteps. Epithets like ‘whore’ and ‘slut’ were written on bedsheets and hung in the room” (Szalavitz, 2011).

‘Attack therapy’ approaches, common among TBS, routinely use verbal abuse and humiliation as part of a ‘break you down to build you back up’ philosophy (Szalavitz, 2006;

Mooney & Leighton, 2019). In the context of ICSA, attack therapy can include ‘slut-shaming’ students and other forms of sexual humiliation, often directed towards women and LGBTQ+ students (Fleck, 2021; Chatfield, 2019). This can be perpetrated by staff and sometimes include coerced cooperation of other students, as reported in a VICE News documentary, “we were instructed to yell things at her like, ‘whore’ ‘slut’” (2021, 3:48- 4:16)⁵. The impacts of this could be devastating to the self-esteem of young people, who may internalise a sense of worthlessness or of deserving of abuse (Herman, 2001). The spectacle of shaming also creates a culture of fear and erodes students' trust in each other.

The normalisation of degrading teenagers as part of the therapeutic milieu is foundational to TBS staff’s ability to deny accusations of abuse and redirect suspicion onto the young person. These degrade and deflect techniques include victim-blaming the young person and casting doubt over their sense of reality and their motivations (Harsey & Freyd, 2020). One participant described her knowledge of what happened to a peer who reported sexual abuse perpetrated by a senior member of staff:

“The girl who was sexually assaulted by the staff member, the clinical director, actually spoke up about it. [The allegations] went to treatment team, he's the head of the treatment team, so he obviously shut it down, said ‘it never happened’ and all of that even though it was suspicious because he had therapy with her in the middle of the night. They'd go for walks and, you know, sketchy things. He made her get up in the middle of ‘community’, which is like the group meeting at night, and apologise for ‘attention seeking’ and ‘making up rumours’ about him. Then she was shamed by all of the higher-level students who, you know, thought she was attention seeking because ‘that’s what the treatment team said, and they’re God’ and all of that. [She] was completely shamed, ‘it never happened’.”

In response to the student disclosing abuse, the abusive staff member ‘shut down’ the allegations and ridiculed the student in front of her peers. He gaslighted and shamed the student, accusing her of ‘making it up’. Despite what should have been obvious red flags (‘night walks’ alone with a staff member), he was not held accountable or subject to external investigation at the time. He relied on his professional authority to deride the testimony of the so-called ‘attention seeker’ student and shield himself.

The public degradation of young people, especially those who allege abuse, is an important deterrent to other students, as well as to staff (Mulvihill, 2022). Victims/survivors, their peers, and non-abusive staff members are perceptive to the power inequalities of believability. In institutional cultures where the insights of young people are regularly derided, young people are conditioned to trust that reporting will be met with disbelief and potentially, a worsening of their situation (Craven et al., 2006). This has reverberations across the institutional community:

⁵ Note the VICE documentary and the Szalavitz news article reported on different therapeutic boarding schools, but both describe the words ‘slut’ and ‘whore’ being directed towards young women in group therapy settings.

“Importantly, cultures often contain content pertaining to the trustworthiness of children. When the cultures of youth-serving organisations feature the assumption that children are untrustworthy, staff members may be less likely to believe the reports of children who are victims or third-party observers of sexual abuse. Further, children who are victims or third-party observers of abuse will be less likely to come forward to disclose the abuse they experience or observe because they doubt they will be believed. Children may be reluctant to report abuse when they expect their reports will be disbelieved because they have little to gain, and expose themselves to the risk of retaliation by the abuser and their allies when reporting the abuse” (Palmer & Feldman, 2017, p. 29).

The young person and the therapeutic community are groomed to believe they are powerless to prevent or report abuse, as one participant said of sexual abuse, “I could not do anything about it”. If young people understand that abuse disclosures are more likely to be met with punishment than protection, they will learn to self-silence as self-protection (Mulvihill, 2022). In TBS these punishments may be formal, such as the ‘dropping’ of privilege levels, or informal such as being targeted for ‘attack’ in group sessions, imposition of seclusion and restraint, physical abuse, and the potential for increased sexual abuse.

Institutions may have staff who co-collaborate in ICSA (where more than one staff member partakes in or condones child sexual abuse) and non-abusive ‘well-intentioned’ staff members who repeatedly fail to effectively intervene or take action to prevent child sexual abuse (Death, 2015; Darling & Hackett, 2020). This cannot be wholly explained by ICSA perpetrators being beyond detection, acting in sly and covert ways. Staff may fail to recognise abuse as abuse for a variety of reasons, having been groomed to trust staff and dismiss students. Lockitch et al. described how non-abusive adults could be groomed and have their protective capacities diminished:

“The perpetrator groomed members of the institution to perceive the victim in a negative light, and the perpetrator in a positive light, thus strengthening barriers to willingness to intervene, and subsequently, capable guardianship” (Lockitch et al., 2022, p. 664).

Staff may fail to recognise abuse and therefore fail to report it, but they may also witness it, be aware of it, and take no action to prevent or report abuse. This can be seen in the case where the TBS staff member accompanied a participant to the pulmonologist, it is unclear if the staff member was working in a collaborative capacity or not, but this staff member took no action to stop the sexual abuse, despite being in the room at the time. At one TBS, multiple staff quit upon realisation of ICSA being perpetrated by colleagues and by management, but they did not appear to have reported these abuses to the police or child protection services.

Complex psychological and cognitive processes are intertwined with institutional structures and can cause a rupture between recognition being followed by reporting (Craven et al., 2006; Winters & Jeglic, 2022). One participant, for example, disclosed staff-perpetrated sexual abuse to a non-abusive member of the counselling staff, who advised him not to report it:

“I remember telling my counsellor, and at that point, he was a bit more sympathetic to me, and I remember him saying, ‘I know, but there's nothing you can do about it, so keep your mouth shut’. I still remember where in that room we were sitting, and his advice to me basically was, ‘I know, I believe you, but you need to keep your mouth shut, don't do anything about this; it will make your life much worse’. Which, you know, to be fair, was probably true. I mean, I hate to admit that it was probably, probably good advice.”

This quote demonstrates the complex dynamics of institutional culture and hierarchy. The TBS had no official reporting process for ICSA, and based on his overall experience of the programme, there was a demonstrable risk of worsening his situation. The suppression of sexual abuse allegations is likely to be sustained unless, or until, there is a willingness to believe young people and trust in institutional reporting procedures (Lockitch et al., 2022). This *lack of trust* operates to strengthen the perceived and actual risk of reporting (Solberg et al., 2021).

The lack of trust extends beyond the confines of the institution to family members and external agencies. When disclosure does occur, there may be inaction, disbelief, or vilification from those outside of the programme in addition to those inside of it (Miller et al., 2022). Craven et al. explain, “Offenders groom the community so well that if a complainant disclosed their abuse, the community may support the offender rather than the complainant because they deem the offender to be more believable than the child” (Craven et al., 2006, p. 293). For one former student, her parents had been groomed not to believe any allegations of wrongdoing. The participant had told her parents about the abuse, but her parents initially did not believe her. Staff had primed them not to trust students:

“They [staff] told my parents, it was, you know, ‘crazy’ me, ‘psychiatric’, ‘insane’, whatever... because I was a treatment kid, and they were the professionals.”

The therapeutic authority of staff members was used to pathologise and undermine the accounts of troubled teens, that a ‘treatment kid’ cannot be relied on to tell the truth or even to know what is and is not real. Staff could gatekeep the narrative by dismissing pathologised young people as “insane”. Another former student’s experience with his parents was similar, when he was an adult no longer enrolled in the programme, he disclosed the sexual abuse to his parents but was not believed, and the topic has since been avoided, “they are in total denial. My father just doesn't want to talk about it, and my mother basically accused me of lying about it.”

Young people respond differently to sexual abuse and extreme, inescapable, ongoing exposure to traumatic violence. As described in previous chapters, students may cope by appeasing staff, mimicking compliance, and not speaking up about sexual abuse. This can include trauma bonding (being ‘brainwashed’), internalising blame, as well as young people ‘participating’ in sexual acts to survive the abuse (Penfold, 1999; Warner, 2019). Dissociative coping techniques, including numbing emotions, feelings of detachment from the body, and repression of memories are common ways victims/survivors cope with sexual abuse and

trauma (Herman, 2001; Joyanna, 2013). As described by Wolf and Pruitt, “a constant state of fear caused by threats of harm, chronic exposure to the perpetrator, and a real or perceived unsafe environment, coupled with limited to no means of escape, would force the child to depend on maladaptive [sic] coping strategies of ‘escape’ such as dissociation” (Wolf & Pruitt, 2019, p. 353). If young people cannot physically escape, dissociation may enable psychological escape to sustain their survival until such a point that they feel safe from harm. These trauma responses are not conscious but serve an important protective function.

Epistemic injustice and institutional grooming

The power of whose knowledge is valued and whose is debased is paramount to the child sexual abuse grooming process (Clare, 1999). Epistemic injustice disempowers pathologised young people and empowers abusive staff to act with impunity. In any circumstance where young people are unlikely to be believed about abuse, society creates opportunities for abuse to occur and be maintained. As Jodi Death succinctly states, “Central to the issue of institutional abuse and cover-up is the exercise of institutional power to silence victims and protect perpetrators” (2015, p. 96). When trust is placed in professionals as the ultimate knowers of and over the lives of pathologised young people, this epistemic violence can be weaponised by perpetrators of institutional child sexual abuse (Raine & Kent, 2019). A culture of denial enables abusers to evade accountability and poses a serious hazard for institutional child sexual abuse.

Violent institutional culture can be used to groom young people for child sexual abuse, and child sexual abuse may be used to discipline deviant body-minds within violent institutional cultures (Clare, 2001; Brown, 2017). As Rachel Litchman, a survivor of the TTI, describes:

“In such a society where mental illness is deeply stigmatised and associated with deviance, mentally ill children are not seen as children, but as threats, nor are they seen as fully human. In a society that also alleges children are unable to understand what’s best for them and creates policies that effectively deny children of the ability to make autonomous decisions, children are denied the right both to consent and to be believed” (Litchman, 2022).

Institutional child sexual abuse is not only the consequence of epistemic injustice but also a means of sustaining epistemic injustice and, thus, broader power inequality (Brown, 2017). To deny the capacity of young people to think and feel, to render their believability as provisional to the approval of authority, is more than a communicative barrier; it is a damning assertion of control of authorities over the bodies of youth.

As adults no longer enrolled in the programmes, there are former ‘troubled teens’ speaking publicly about their experiences of institutional child sexual abuse (Stockton, 2022). As adults, they have access to more conceptual and linguistic concepts to explain and process their experiences as institutionalised youth. Wider access to hermeneutical resources, such as social media, online support groups, and TTI survivor friendships, provide communicative opportunities for validation that were previously denied to them. At the time of the

interview, one of the interview participants was qualifying to become a social worker, and she described how this helped her to understand her experience in new ways:

“I was brainwashed [at TBS] ...now professionally going into social work, I see a lot more of the actual terminology, if you want to call it that, I can see more of the power dynamic, the abuse, the neglect, the things that I didn't notice as problematic before. Now that I have a background of what is appropriate, I notice more of what isn't.”

As more students have spoken up about sexual abuse, this provides validation for other victims/survivors, including those who do and do not openly discuss their experiences. There are now concerted and collective efforts to acknowledge what appears to be widespread institutional child sexual abuse within the industry (Hampton & Kircher, 2022).

Implications for practice

It is likely that institutional child sexual abuse takes place in the troubled teen industry on a much larger scale than is currently acknowledged. Psychiatrised victims/survivors are unlikely to disclose ongoing abuse, and many will take years or decades to tell even those whom they trust most (Stige et al., 2020; Halvorsen et al., 2020). Therefore, it is crucial to acknowledge that institutional child sexual abuse can occur at any TTI facility, including in programmes where there have been no formal abuse allegations. Every programme should be understood as having the potential to harbour perpetrators of ICSA (Smidt et al., 2023; Lockitch et al., 2022). Research contends that institutional systems and cultures can heighten the risk of staff-to-student sexual abuse (Erooga et al., 2020; Falkenbach et al., 2019; Martschuk et al., 2018; Raine & Kent, 2019; O’Leary et al., 2017). ICSA is more likely to occur in programmes with unchecked staff power, closed and secretive institutional norms, and where young people’s testimony is treated as suspicious (McAlinden, 2013).

Several practical policy and practice interventions could reduce the risks of ICSA and help identify occurrences. Within institutions, there need to be clear and robust reporting procedures, which should be made with the knowledge that perpetrators could be part of the management team (Erooga et al., 2020). Staff should receive training on warning signs of abuse, common grooming strategies, and whistleblowing procedures (Lockitch et al., 2022). Young people should have opportunities to disclose abuse to staff and professionals outside of the TBS and be listened to affirmatively without risk of punishment (Solberg et al., 2021). For young people to disclose abuse in these institutions, however, there would need to be a consistent demonstration that they will be believed, supported, and can speak to people who will act in a protective capacity, that they will not be shamed, blamed, or accused of being manipulative (Stige et al., 2020; Milne & Collin-Vézina, 2014; Miller, 2022b). Opportunities to access young people unaccompanied in closed spaces should be reduced or eliminated (Palmer & Feldman, 2017; National Disability Rights Network, 2021). Staff should be required to have criminal record checks. However, most CSA perpetrators will never face abuse charges and have no criminal record (Winters & Jeglic, 2022). The risk of ICSA is a reality that cannot be wholly eliminated but should be carefully accounted for in programme design and oversight.

Confronting institutional child sexual abuse in therapeutic boarding schools is not a process of weeding out 'bad' staff members; it requires a radical overhaul of the violence of troubled teen industry institutional culture (Death, 2015). There is a need to understand how institutions can enable people to commit child sexual abuse and access vulnerable young people while evading detection, including through the structural and social disempowerment of young people in the troubled teen industry. Programmes that do not robustly account for and address these risks have abdicated their duty to protect children and young people from harm (McNeish & Scott, 2018; Winters & Jeglic, 2022). A quote from one participant underscores this urgency, "The first rule of social work, rule number one, no matter what, do no harm. That's exactly what you guys have done, more harm. Yes, I'm alive, maybe because of you, but what I've been through is almost worse than death."

Conclusion

The sexual grooming of young people in the troubled teen industry is an epistemic manipulation that claims authority over the young person's body-minds. It systematically undermines young people's ability to recognise, report and resist child sexual abuse. The 'troubled teen' receives messages from multiple fronts in multiple forms that their consent is not required, that they lack full capacity as knowers, and that staff have control over them. 'Troubled teens' have been systematically undermined by practices of silencing, whether it be by restraining them, isolating them from others, or shaming them as 'sluts' and 'whores' (Szalavitz, 2011; Miller, 2022b). Abusive staff members wield their professional status to enhance their perceived credibility and draw on the stigmatisation of pathologised youth to discredit abuse allegations (Erooga et al., 2020). Non-abusive adults often fail to intervene, and young people self-silence to cope and survive (Lockitch et al., 2022). Perpetrators of ICSA have made opportunity of the 'troubled teen industry', identifying a vulnerable population, gaining extensive access to and isolating young people, cultivating trust in their positions as professionals, disguising invasive touch as treatment, and pathologising young people who step out of line. A lack of research means the extent of ICSA in therapeutic boarding schools is unknown, but the accounts of those who have come forward stress the urgency for more work to address the topic.

Chapter ten: Conclusion

This chapter includes reflections on the research process, policy and practice implications, theoretical considerations, and directions for future research and activism. I draw on interview participant quotes to highlight the varied perspectives of former students/survivors. In the interview, one of the questions I asked was about what changes to the industry participants would like to see; it felt important that their voices be represented here. I close the thesis with a summary of key takeaways and my hopes that this work can help contribute towards social change.

Research aims

The research had four key aims:

1. To produce knowledge that centres the perspectives of former therapeutic boarding school students.
2. To document and analyse former students' experiences before, during, and after their time in therapeutic boarding schools.
3. To analyse the role of institutional culture in the experiences of former students.
4. To increase awareness about troubled teen industry abuse, maltreatment, and human rights violations.

I believe the research has met these aims:

1. The study has centred the perspectives of former students/survivors.
2. Multiple forms of abuse, as well as broader therapeutic boarding school experiences, have been documented.
3. The theoretical lens has focused on how sanism, adultism, and epistemic injustice operate in violent institutional cultures.
4. The research has reached a wide audience and helped raise awareness about abuse, maltreatment, and human rights abuses in the industry.

Overall, I believe the research has created useful insight into the experiences of former therapeutic boarding school students. The status of the industry and the scale of harm that is apparent in my research highlights the importance of research into this topic.

Research impact

A central ambition for the research was to produce work that resonated with former students and survivors. The first research publication has reached a relatively large audience and generated positive feedback. The article, 'Troubling the troubled teen industry: Adult

reflections on youth experience of therapeutic boarding schools' (2020), has been viewed over 25,000 times. My research has appeared in *Huffington Post Canada*, *The Conversation*, and *Mad in America* (Beattie, 2020; Mooney, 2021; Lejeune, 2022). The article is referenced for the 'troubled teen industry' definition on Wikipedia. Further, I have had former students/survivors write to me saying it was one of the most accurate articles they had read, affirmed their experiences, and helped them to better understand what they had been through. I have been contacted by parents, social work students, and a former staff member who wanted to support survivor activists. I have also had the opportunity to work as an expert consultant for an upcoming TV series. That people care about this topic and are reading my work has been deeply meaningful to me and more than I could have imagined for this research.

Reflections on the research process

The research process has been a long, winding path with unexpected turns. It has challenged my perspective on everything from the details of data analysis to research ethics to the foundations of Mad Studies. While there is much for me to continue to mull over, I have chosen to include discussion that focuses on two areas of research: the limitations of case study design and the complexity of trauma memories in the narration of lived experience.

Limitations of case study research

In social research, we often utilise concepts of anonymity and confidentiality without critically reflecting on what this entails. There is a lack of consensus on what constitutes 'confidentiality', the removal of names and places or the obscuring of all details to prevent any potential participant identification. There are further questions if participant anonymity should be the default position at all, as some want named recognition of their experiences and contributions (Saunders et al., 2015; Guenther, 2009). Due to the amount of contextual detail revealed, this is a critical issue for case study research (Crowe et al., 2011). Although I use pseudonyms and have obscured some details, a couple of participants requested in the feedback process for further details to be removed or rephrased. I accommodated these requests. For this reason, on reflection, I think case studies should only be produced when participants have expressed a prior commitment to involvement in the creation of their case study. There are potential practical difficulties with this, including time considerations and participant attrition. The case study feedback process also raised an ethical dimension I had not fully considered, the feeling of exposure as experientially different from the actual risk of being identifiable. One participant described anxiety about her case study being potentially identifiable to her parents, even though she reflected, "I know they will never read it".

The limitations of case study research have meant I have not been able to include all participants as case studies in this thesis. This was not a reflection of the quality of interview or the importance of their therapeutic boarding school experience. I hope to include many of the interviews as the basis for case studies on future publications, specifically on topics related to authorised kidnapping/forcible transportation, peer surveillance, and potentially for further work on the experience of men, a population who have often been underrepresented in research and media coverage. I may write a book based on the

research in the future. I would also like to conduct further research, including large-scale quantitative surveys, to add complement the doctoral research.

Retrospective accounts, trauma memories, and epistemic injustice

My research approach has not sought to establish truth-as-fact, accounts independently verified as objective or accurate, but rather truth as subjective understandings of the past (Nichols, 2021). Many of the abuses discussed in this thesis would be impossible to verify as the secrecy of institutional abuse can preclude the possibility of eyewitnesses, and the power of institutional cover-up draws into question the reliability of official records (Jelin, 2003). It is not the prerogative of this research to achieve the legal threshold of evidence, to prove what 'really happened'. I have interpreted participants' accounts as speaking their truth, and therefore, I have taken a generally affirming stance in how I have described what former students/survivors have told me. Whilst I cannot attest to the accuracy of specific accounts of abuse, the frequency in which various forms of abuse were discussed in my research, as well as in research and reports beyond my research, suggest that severe abuse in these programmes is more than the subjective truth of select individuals. It is on this basis that I make claims of industry-wide abuse.

Interviews focusing on retrospective accounts of traumatic memories and abuse experiences entail an intricate interplay between the cognisance of the here and now and our relationships with the past. They provided a window into past experiences that were often framed by common coping mechanisms such as minimisation, denial, avoidance, and dissociation (Stige et al., 2020). After a description of multiple incidents of institutional violence, one participant said, "Some people had it worse, and that's what I try to tell myself". In interviews, many described how their understandings have changed over time,

"In hindsight it was terrible. I think when I was there, I had a honeymoon period and like, 'Oh, maybe, they did help me out with this, that and the other thing'. The more I look back at it the more I'm like, 'That was fucked up'."

This complicates concepts of epistemic injustice, as many reflected in adulthood that the depth of their trauma and ongoing exposure to violence made them unable to consciously process abuse during their institutionalisation as youth (Lo, 2023).

Trauma brings the necessity to a dynamic understanding of epistemic injustice. It can block our ability to recall, process, name, and speak of our experiences (Wolf & Nochajski, 2022). This is not to discount the insight of psychiatrised youth but to acknowledge that trauma has manifest implications for recall and self-understanding. These can be present even decades after the abuse. We all narrate a variety of experiences of the self and our life histories, and trauma can be an important driving force in which narratives become spoken. As one participant discussed,

"There are two ways I can tell this story; I can tell it by just completely disconnecting and just going through a bunch of details, or I can tell you the real version, but it's too unbearable to tell the real version."

The sharing of experience can be a powerful source of validation. Yet, the flip side of validation can be disruption to depersonalisation. One participant reflected in the case

study feedback process that reading about her experiences felt validating and “makes it feel more real”. These pathways of forging epistemic justice for trauma victims/survivors can be healing, tumultuous, and revealing.

Implications for policy, practice, and future research

In this section, I describe potential avenues for legal reform, improving social care interventions, and the need for more survivor-centered research. In previous chapters, I have discussed more specific implications and interventions on LGBTQ+ ‘conversion therapy’, seclusion and restraint, and institutional child sexual abuse. Knowing how to tackle institutional violence in therapeutic boarding schools is a difficult task fraught with obstacles and limitations. My recommendations are underscored by an awareness of the complexity of their implementation. This is a practical challenge and a challenge of corruption and lack of political willpower. There is no single way forward, but I believe the most progress will be made by a multitude of ways forward. The troubled teen industry is embedded in broader legal and cultural practices that would require transformation before, I believe, genuine transformation or abolition of the industry could be achieved. Although survivor activism has gained momentum, the current status of anti-trans bills across the country reminds us of how fragile children’s rights are in the USA (Stahl, 2023). This presents an even greater challenge with heightened urgency.

Law and policy

I suggest law and policy reform should be addressed in multiple ways. The first is to enhance oversight and close regulatory loopholes. Second, specific harmful institutional practices should be banned. Lastly, there is a need to promote the rights of youth and psychiatrised people.

Oversight and regulation

There is a clear and long-established need to enhance government regulation and oversight, at both the state and federal level (U.S. Government Accountability Office, 2008b; Friedman et al., 2006). A definitional consensus of what constitutes a ‘therapeutic boarding school’ is essential to implement this. There is a need for improved government data collection and for this to be standardised at a federal level (National Disability Rights Network, 2021). Among many potential reforms, residential programmes for children and youth should require licensure and routine unannounced independent inspection (Whitehead et al., 2007; Evans, 2022). The government should address loopholes that exempt privately funded and faith-based programmes (Szalavitz, 2012). Professionals who work with children in residential facilities should have to undergo criminal record checks. Accreditation organisations should be subject to government scrutiny and regular quality assurance checks. Legislation should ban specific practices, such the misuse of seclusion and restraint, food and sleep deprivation, forced labour, and forcible transportation. One survivor stated, “transports need to stop; it just needs to stop.” These laws would need to be routinely reviewed for their effectiveness.

Promotion of human rights

A vital way to improve the treatment conditions for ‘troubled teens’ is to promote the rights of children and psychiatrised people. This includes challenging presumptions made about

the mental capacity of psychiatrised youth, ‘troubled teens’ perspectives should be centred in decisions made about their healthcare (Sutterlüty & Tisdall, 2019; LeFrançois & Coppock, 2014). Young people detained in residential facilities should have the right to independent evaluations and appeals processes (Polvere, 2011). As one former student described, “I don’t think that out-of-home placement for youth is appropriate unless they have some form of due process”. Several participants referenced that therapeutic boarding school students should have unmonitored phone access to advocates, helplines, and police. Young people should have the right to contact people outside the institution and spend time off-campus regularly. Conversion therapy, seclusion and restraint, institutional child sexual abuse, and the abuse of psychiatrised children in residential facilities more broadly are human rights abuses that the government has an obligation to investigate and take action to prevent.

Limitations of legal reforms

The troubled teen industry's lack of regulation and oversight is not due solely to a lack of political awareness. The industry is hugely profitable and has powerful financial lobbying power. Multi-billion-dollar private equity firms like Bain Capital own therapeutic boarding schools and troubled teen programmes (O’Grady, 2022). Therapeutic boarding schools provide job opportunities to rural communities and bring significant state and local tax revenue. In one report conducted by researchers at the University of Utah in 2015, the state’s ‘family choice behavioural healthcare interventions industry’ generated “6,400 jobs, \$269 million in earnings, \$423 million in State Gross Domestic Product (Utah GDP) and \$22 million in state and local tax revenue” (Tennert, 2016, p. 1). There are also politicians who have personal financial connections to the industry, such as Republican Senator and former Presidential Candidate Mitt Romney (Madigan, 2012). For conservative Christian politicians, many of whom are Evangelical or Mormon, the industry represents ample opportunity to impose Christian values on the lives of ‘deviant’ youth. For example, former Vice President Mike Pence endorsed a programme known to practice LGBTQ+ ‘conversion therapy’, and former President George W. Bush helped direct funds to faith-based programmes like Teen Challenge (Sugiuchi, 2016; Colloff, 2001; Dufton, 2012). For many legislators, it is in their political and personal interests to ensure the industry continues to prosper uninhibited by government intervention.

Social work practice

The insights of former students and survivors should compel social workers to critically reflect on our practices. One of the most urgent needs is affordable and accessible mental health treatment in the community. This would require enhanced state funding and expanded health insurance coverage. However, there is no ‘one size fits all’, and each person would need to be supported according to their needs. As with law and policy, implementing these strategies is complex, and the ideal is not always practically attainable. As one participant aptly summarised, “I would really hope to see a change in the industry, and I would really hope to see more beneficial relationships for teens coming into adulthood. I don’t know what that would be like; I wish I did. I wish to hell and back I did.”

Improved community support

There is a need for improved community-based access to mental health support for children and young people. Affordable trauma-informed counselling for victims/survivors of abuse

would be especially beneficial (Emond et al., 2016). Rather than pathologising children and young people, blaming them for their actions, or labelling them ‘out of control’, adults should seek to establish more trusting dialogues to understand the meanings behind ‘dangerous’ and ‘destructive’ behaviour (Chandler, 2016; Roesch-Marsh, 2014). Participants repeatedly described that if they had been responded to with empathy and offered support earlier, they would likely have never been sent to a therapeutic boarding school. Furthermore, interventions that focus on the whole family, including support for parents struggling to cope with their child, can have a significant positive impact on the young person and the family (Norton & Cuskelly, 2021). However, there will be crisis circumstances when more intensive residential options may be necessary. One participant reflected that without an intensive residential placement, she may not be alive today, “I’m glad I’m alive; I don’t know if I would be”. Residential facilities should be based on the principles of placing children in the least restrictive environment and honouring young people’s rights as much as possible (Services, 2015).

Consent-based engagement

A need for consent-based practice was one of the most common suggestions made by participants. They repeatedly described the harm to individuals and the therapeutic relationship, “I don’t think you can have a healthy therapeutic process without consent. I think that has to be first and foremost”. Forced and coerced therapeutic engagement was experienced as harmful and the institution as manipulative (Polvere, 2011; Jordan & McNiel, 2020). In addition to overt and covert abuses, the lack of consent constituted a form of ‘institutional betrayal’, a term used to describe “when an institution causes harm to an individual who trusts or depends upon that institution” (Smith & Freyd, 2014, p. 578). As one participant discussed,

“When you don't have consent, it's manipulation. You're working outside of a boundary that's something that's so personal and is so dear to somebody; it's their own thoughts and feelings. It comes into an almost authoritarian view. I think that does a lot of damage to people's interpersonal relationships, to their sex relationships, to their life in general, especially to their relationship with themselves.”

The betrayal of trust and the position of vulnerability experienced by institutionalised youth make it especially important for social workers to support and listen to young people and meaningfully collaborate with them in decision-making. The social work relationship should promote epistemic justice by valuing the insights and wishes of young people (Baumtrog & Peach, 2019; LeFrançois, 2020). Improvements to child mental health advocacy networks could further this aim by enabling young people to access third-party information and advice.

For residential care professionals, there is cause to reflect on institutional practices critically. Many therapeutic boarding schools are purportedly ‘voluntary’ and may look consent-based on paper, but are experienced by young people as coercive institutions where their compliance is marred by the threat of being sent ‘somewhere worse’ (Dobud, 2022; Chatfield, 2019; Szalavitz, 2006). One former student became a staff member after she graduated, an experience she reflected on,

"I don't think anyone gets into the industry of trying to help people with bad intentions. I think that all of those people start out, including myself, with very good intentions to try and do the very best that they can to be kind and loving. And I don't think that it's possible to do the kind of work that we would really like to see ourselves doing as long as the structure exists as it currently does."

While there are some who intentionally abuse children, the history of social work reminds us that some of the most violent social interventions were led by people who held earnest beliefs that they were helping (Chapman & Withers, 2019; Rodriguez et al., 2020).

Support for adult former students/survivors

All participants expressed a need for counselling and mental health support, a process that, for some, remained ongoing. Several former students/survivors described a process of "unravelling" the harmful messages they had internalised from the programme. A participant described one of his most impactful memories from the time, "what I remember the most was just being misinterpreted and pathologised, feeling like I was broken". Most participants described complex post-traumatic stress. Many had difficult relationships with their parents. Some struggled to establish trusting and healthy intimate relationships. In adulthood, several had repeat drug addiction relapses; some attended adult residential treatment facilities, and one interview participant had experienced imprisonment. Mental health support for adult survivors is made even more urgent by high rates of suicide and drug overdoses. Several participants described that one or more of their TBS peers had died by suicide; "There's a lot of people who have killed themselves." Yet, despite there being thousands of former students and survivors, there is hardly any specialist counselling services for them. Government funding and expanded insurance access, as well as specialist TTI awareness training for counsellors, would help address this unmet need. However, there would remain barriers to access, including a lack of trust in mental health care; one participant described being unable to go to counselling because she feared being "sent away again".

Directions for future research

The lack of available data on the troubled teen industry demonstrates a crucial need for further research. Research is needed on a wide range of issues, many of which have yet to be addressed in academia. Scope for future research includes large-scale surveys that gather demographic information about former 'troubled teens', the types of facilities they have attended, their experiences, and the long-term impacts. Research addressing specific topics would also be of great benefit, including the effects of peer group 'attack therapy' and the mental health impacts of peer surveillance. More research is needed on how young people can be supported to safely report abuse in 'troubled teen' residential facilities. Research should look further into psychological coping mechanisms, including trauma-bonding and dissociation, and how this impacts students' self-understanding and ability to disclose abuse (Herman, 2001). There is also a pressing need for researchers to assess troubled teen industry programmes located outside the US. This is especially true of Canada, where troubled teen facilities have gone largely unacknowledged in the literature despite a clear online presence of programmes recruiting students (Venture Academy, 2023; Freedom Village Canada, 2023; NATSAP, 2023e).

Methodological considerations

While there is a clear need for more research, this is not an unqualified need, and some research can do more harm than good. There are serious ethical concerns about research conducted by or with industry professionals, including conflicts of interest. One interview participant described the discrepancy between her lived experience and the industry's 'success' narratives,

"In the eyes of the programme, as an adult, I'm a success story. I'm one of the kids they want to talk about because on the outside everything looks great, but, like, holy shit. I have like nightmares constantly, I can't sleep. What happened [at TBS] was not helpful."

The industry measurement for success has limited validity if it fails to understand the lived experiences of former students/survivors. In addition to this, current and former students may not trust researchers perceived to have connections with the industry, further damaging the validity of their results (Ellard-Gray et al., 2015).

Researchers who access those presently institutionalised must critically reflect on who and what they are given access to see (Andow, 2020). TTI facilities will likely engage in institutional impression management and it may be difficult to get an accurate picture of life in therapeutic boarding schools (Kendrick & Taylor, 2000). Therefore, the role of gatekeeping in institutional access poses substantial limitations to the accuracy of research outcomes. One participant told me,

"The system was designed to prevent information from getting in and prevent information from getting out as much as possible so that parents would not have any idea what was going on."

Research with current students also raises safety and confidentiality issues, and students may be unlikely to trust that they can speak openly and honestly. Moreover, as the quote above exemplifies, parents' perspectives should not be used as a proxy measurement for former student/survivor success.

In general, I consider research that relies on institutional access to be potentially harmful to former students/survivors of the troubled teen industry. I would like to instead see academics, activists, and advocates collaborate in research independent of the TTI. Some suggestions for this work include building definitional consensus about what constitutes the 'troubled teen industry' and establishing awareness raising goals. TTI research would benefit from skill-sharing, collaboration, and coalition-building with broader social justice and human rights campaigns. As one participant and activist described,

"I would like to see people and organisations who concern themselves with other rights issues- disability rights, children's rights, anti-torture campaigners, and solitary confinement. I would like to see them pay attention to this and see their own issues as encompassing this."

Coalition-building would help to address the lack of research on Black and Indigenous 'troubled teen' experiences and the experiences of state-funded therapeutic boarding

school students. Access to this population would require ‘insider’ knowledge and collaboration with Black and Indigenous-led organisations (Islam et al., 2021).

Truth commission

The public would benefit from robust and official documentation on abuse in these institutions. A government commission should investigate the history, scope, and impacts of abuse in the ‘troubled teen industry’. This would help to raise awareness, identify governmental and social care failures, make official recommendations, and validate the experiences of survivors (Lundy, 2020). I believe the scale of abuse indicated by my research and others warrant an inquiry of this stature (Spandler & McKeown, 2017). In 2007 and 2008, the U.S. Government Accountability Office released reports on troubled teen facilities, but these did not engage with former students/survivors to document their experiences (GAO, 2007). Numerous examples of commissions from across the globe have investigated institutional abuse, including Ireland’s Commission to Inquire into Child Abuse (2009) and Australia’s Royal Commission into Institutional Responses to Child Sexual Abuse (2017). In the USA, a government-issued investigative report on Federal Indian Boarding Schools was recently published (Newland, 2022). However, this was not a full truth commission. The TTI survivor-advocacy movement stands to learn much from the activist work of the National Native American Boarding School Healing Coalition (National Native American Boarding School Healing Coalition, 2020).

Theory and action

This research has been rooted in an activist commitment to contributing to change. My hope for this research is that it can be a useful resource for awareness raising, and for former students/survivors’ self-understanding. The themes discussed in this research also have important implications for wider campaigns for social justice and liberation. The context of the ‘troubled teen’ draws into critique reductive and binary logics of privilege and marginalisation and how this relates to institutional violence. While I have drawn on Mad Studies as foundational insight for understanding the experiences of psychiatrised youth, my research also contains provocations for Mad Studies. The troubled teen industry is an example of how peer-led and demedicalised approaches can be the source of profound harm, not liberation. There is much to be gained through multi-issue organising, and I believe this is important for the future of troubled teen industry activism as well as related campaigns to end institutional violence.

Intersectionality: Narrating privilege and ‘troubled teens’

Kimberlé Crenshaw, who coined the term intersectionality, has explained, “intersectionality is simply about how certain aspects of who you are will increase your access to the good things or your exposure to the bad things in life” (Crenshaw in Steinmetz, 2020). Writing on intersectionality has typically focused on how people with social privilege can experience violence and adverse life experiences despite their privilege and not because of it. My research complicates this assertion, as wealthy families are systematically targeted due to their ability to afford costly programme fees. In other words, ‘troubled teens’ often experience institutional abuse, in part, because of their privilege and not despite it. This has important implications for how we understand institutional child abuse in our society. The assumption that institutional child abuse and torture do not happen on a large scale in

modern-day America, and especially not to people who are rich and white, has contributed to the troubled teen industry being able to prosper for so long under the radar. This operates in conjunction with the normalisation of violence in institutions that disproportionately incarcerate people of colour, such as prisons and immigration detention centres; it is no secret these are violent places for youth, even if people often choose to ignore it.

It is important also to acknowledge ways that intersectionality contributes to understanding the 'troubled teen' experience – both during and after the period of institutionalisation. Rich, white 'troubled teens' endure horrific experiences of abuse, but they do not endure them *in addition to* racism and classism. Many 'troubled teens' hold multiple marginalisations, such as being women, being LGBTQ+, being neurodivergent, and some are racialised or are from low-income backgrounds. These students may be subject to specific forms of abuse within the industry, as well as targeted and intensified levels of abuse. Once having left the TTI, there are tangible differences between those who have been through the TTI and those who have been through the prison industrial complex. The privilege to circumvent the criminal justice system, to be 'mad' instead of 'bad', is exemplary of the insight intersectionality affords us (Ben-Moshe et al., 2021). Middle and upper class white teens who use drugs and get 'treatment' instead of prison do not leave with criminal records. Therefore, there are potential opportunities afforded to troubled teens which are closed to the formerly incarcerated. However, it is important to acknowledge that each person's experience will be different and there remain substantive barriers for 'troubled teens'.

In my research, the case study approach complicated the relationship between intersectional analysis and narration of people's individual experiences. The individual-level analysis posed limitations for addressing systemic inequalities, especially in under-researched areas of study where broader patterns of experience have yet to be established. Therefore, I have been unable to make claims regarding if one demographic group is subject to worse TTI conditions, and experience worse long-term outcomes, than another. I have felt tension between the desire to analyse individual's experiences as part of a broader race-class-gender-sexuality-disability analysis and efforts not to extrapolate from individual experiences assumptions about broader social groups (i.e., 'women's experiences') (Nash, 2019). Intersectionality can be misapplied in ways that treats identity as quantifiable qualities with an explanatory power that does not always 'fit' an individual's experience. As case studies focus on the individual experience, I have generally focused on how participants identified experiences of discrimination or oppression. This was both a limitation of my analysis and a cause for reflection on how intersectionality gets taken up in academia (Bilge, 2013). I hope future research will help fill in these knowledge gaps and allow for improved understanding of intersectional oppression and the TTI experience.

Troubling Mad Studies

In a departure from Mad Studies literature that seeks the demedicalisation of mental distress as one of its key goals, many former students/survivors called for enhanced medicalisation in the treatment of 'troubled teens'. These participants described a need for evidence-based interventions, independent psychiatric evaluation and diagnosis, and facilities run by licensed mental health professionals; "at least there's some professionalism

and peer-reviewed literature behind it". One former student described a need *for* medical pathologisation; he explained young people "need a thorough diagnosis, and there needs to be good therapeutic care, treatment that fits and works". While no participant described psychiatric hospitalisation as a 'good' outcome, it was frequently described as a better option than unregulated troubled teen facilities. Strategically, these changes may be better in the short term than no changes. As a Mad Studies activist-scholar, the troubled teen industry has posed important and ongoing challenges to my perspectives. Under these circumstances, might medical regulation be better than no regulation? How can mad praxis contend with this?

Mad Studies would benefit from further consideration of how medical alternatives can be oppressive, dehumanising, and the source of profound harm to mad people. Therapeutic boarding schools originated in part as 'alternative therapeutic communities' (Shea, 2017; Safran, 2018). While most facilities use psychiatric drugs, others have refused them (Bratter, 2007). TBS often hire ex-students as experiential 'experts' without any formal qualifications or licensure (Szalavitz, 2006). The 'lived experience expert' can become mad youth's captor; further, the 'lived experience expert' themselves may be captive in the troubled teen system, which uses their 'overcoming' narratives as a proxy for evidence of treatment effectiveness. Experts by experience can enact cruelty by experience. 'Alternatives' to psychiatric hospitalisation can become divergent forms of sanist confinement and social control. The issue has received attention in Global Mental Health literature on 'folk' and 'traditional' medicine, but it has seldom been addressed by Mad Studies (White et al., 2014; Kpobi & Swartz, 2018; Gureje et al., 2015). To be clear, I am not arguing for the psychiatrisation of the TTI or the hospitalisation of teens in distress; residential treatment centres with social workers and psychiatrists on staff exemplify how medicalised troubled teen facilities do not work. I am calling for Mad Studies to refine its approach to liberation and acknowledge these complexities.

Divergent forms of confinement and multi-issue organising

The troubled teen industry poses many unique challenges and potential contributions to activist and academic understandings of care and control institutions. Troubled teen industry activism ought to be included as part of broader struggles to resist divergent forms of forced confinement, including imprisonment and involuntary hospitalisation, and vice versa; we need to include these resistance struggles in our thinking and organising. The troubled teen industry exists because of its unique positioning as a profitable 'alternative' to hospitals and prisons. Regulation does not offer solutions to the problems of institutional abuse, nor does uncritical reliance on community interventions. Therefore, our work is inadequate if we fail to consider the multiple forms and harms of confinement. Our commitment to change requires us to think beyond the immediacy of our single-issue focus to address interrelated systems of control and domination.

Campaigns for prison abolition describe imprisonment as inherently oppressive, as a form of social control and violence perpetrated disproportionately on racialised and poor people (Critical Resistance, 2020). Abolition proposes that prisons be abolished/reduced, and that society needs to be transformed to address the causes of interpersonal and structural violence (Lamble, 2020; Davis et al., 2022). Abolition requires more than just the closure of prisons, "abolition is about abolishing the conditions under which prison became the

solution to problems” (Gilmore & Murakawa, 2020). Building an abolitionist future requires many steps and strategies, including community alternatives to imprisonment. This last point is one where the troubled teen industry gives reason for caution. Carceral expansion can move beyond the prison to new and evolving industries of control, and prison diversion could lead to increased reliance on alternatives like therapeutic boarding schools (Richie & Martensen, 2020). While I do not propose either prisons or the TTI to be ‘better’ than the other, I do want to draw our attention to the ways both cause harm and the need to address this in activists strategising.

As I appeal to prison abolitionists to contend with the troubled teen industry, so too should TTI activists engage in cross-carceral movement building. Troubled teen industry activists and academics would strengthen our movements for change if we were to work collaboratively with prison abolitionist and disability justice movements, as well as the work of Indigenous residential school victims/survivors. This would necessitate humility in our organising efforts; our stories are important and should be heard, but they are not more important or tragic than poor and racialised victims/survivors of youth detention centres. Troubled teen industry activism should move away from appeals to our innocence, that we did not deserve what happened to us because of not being criminal or not being crazy. We do not deserve to be treated like criminals because no one deserves to be treated the way American society treats criminalised populations or institutionalised disabled populations. No one deserves to experience institutional abuse and torture, especially children, regardless of which form of institution they are sent to and what they have been diagnosed with or sentenced to. Our cause is to end institutional abuse wherever it arises and whoever it targets.

Numerous reforms to policy and practice could be implemented to help protect young people in private residential facilities and address abuse in the troubled teen industry. To achieve these reforms, there would need to be greater political willpower to regulate the industry robustly, and the government would need to provide more funding for community-based mental health support for children and youth. However, while reforms may make inroads heading in the right direction, they cannot make an industry with a decades-long history of abuse safe. Abolishing the troubled teen industry would help to end its violent legacy. However, abolition also faces challenges as the financial opportunity is so great that some form of therapeutic boarding school would likely emerge under a new name and adapted branding. As Angela Davis advises, “abolition is not just about changing institutions, it’s about changing people’s ideas, it’s about changing prevailing ideology” (Davis in Phifer, 2022). For as long as society considers young people ‘trouble’, there will be institutions ready to control them.

Concluding thoughts

Thousands of young people are held in the troubled teen industry every year under the auspices of residential care for ‘out of control’ youth. Therapeutic boarding schools, as part of the troubled teen industry, have operated for decades with little independent oversight. The research conducted for this thesis paints a disturbing picture of abusive conditions that have taken place behind closed doors. Participants described a myriad of human rights abuses as well as emotional, physical, and sexual abuse and neglect perpetrated by staff

towards students. In this thesis, I focused on several forms of institutional violence: LGBTQ+ 'conversion therapy', seclusion and restraint, and institutional child sexual abuse. I have concluded these abuses were not solely the consequence of individual 'bad actors'; the abuse was structural and embedded into everyday institutional life.

Foundational to the perpetration and continuation of institutional abuse is epistemic injustice, the devaluing of the insights of psychiatrised youth confined in the troubled teen industry. By constructing the 'troubled teen' as crazy and manipulative, staff have attempted to control the public perception of therapeutic boarding schools. Staff present themselves as benevolent experts, and the teenagers as lacking reliable testimony unless and until these insights are seen to align with that of the professionals. Therefore, young people have often been disbelieved, and in turn learned to anticipate disbelief and self-censor to survive. Further, young people are often literally silenced by the programmes: cut off from contact with the outside world, put on 'speaking bans' which make talking a punishable offence, and placed into seclusion 'isolation rooms'. In the face of extreme circumstances, 'troubled teens' cope in a variety of ways, including through forming trauma-bonds with abusive staff, internalising harmful messages, and blaming themselves for the abuse they have been forced to endure. Students have also resisted their institutionalisation in subtle and overt ways, including disobedience, running away, and mimicking compliance. In the years and decades since leaving the therapeutic boarding school, many former students continue to struggle with the trauma they endured in the troubled teen industry.

The conditions inside these programmes have gained substantial media attention of late, but beyond the headlines few academic studies have analysed therapeutic boarding schools from the perspective of former students. As a survivor-researcher, I have sought to listen to the stories of former students/survivors, document their accounts, and critically analyse the role of therapeutic boarding school institutional culture. The testimonies are powerful, and I am deeply grateful to the participants who shared their stories with me. While I can never fully do justice to all they have been through, I hope participants feel heard and believed and know they have contributed to shining a light on abuse in this industry. Conducting this research has changed how I understand my own experiences, and it has furthered my dedication to utilising the tools of academia to raise awareness about the industry. I hope that this thesis can serve as a useful resource for campaigning for change and, for some former students/survivors, that this work can be helpful for understanding and processing the past. There are many barriers to creating the change necessary to end abuse in this industry, but if nothing else, I am thankful for those of us who try and that more and more people are starting to listen.

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Appendix

Appendix 1- Questionnaire

Appendix 2- Interview information sheet

Appendix 3- Interview consent form

Appendix 4- Interview questions

Appendix 5- Case study feedback outreach email

**Therapeutic Boarding Schools: Narratives of Former Students
Questionnaire**

Opening Page – Consent form

Welcome!

I am a PhD student conducting in-depth interviews with former therapeutic boarding school students. If you are a former student of a USA-based therapeutic boarding school and are interested in participating in an interview, please register your interest by continuing to complete this online form. If you are interested to know more about what the study, please visit the [Therapeutic Boarding School Research Study Website](#).

The registration process and interviews are confidential and voluntary. In order to participate in the research, you need to be 18 years of age or older and have been a boarding student in at least one therapeutic boarding school in the USA. The registration will ask questions on your background, the school(s) you went to, your experience of the school(s), and contact information. A selection of those who have registered interest will be invited to participate in interviews, either in person, over the phone, or by Skype.

For the purposes of this research, a therapeutic boarding school is a residential school or academy aimed at teenagers who are considered to have mental health problems or substance misuse issues. They may also be known as 'emotional growth boarding schools'. The schools typically run 365 days a year, have on-site accommodation, have at least several hours of taught classes on an average weekday, and limit contact with family and peers outside of the school. More detailed information can be found on the study's website.

All responses will be stored securely, according to UK research council security regulations, and your information will be kept confidential. Your personal information will NOT be shared with any outside institutions or individuals. In publications based on the research, your responses will be anonymous and any identifying information removed. This research has been approved by the School of Social and Political Science Board of Ethics, University of Edinburgh, Scotland.

The registration process should take around 15-20 minutes to complete. You can stop and return to the questionnaire, or choose to stop at any point.

Please contact TBSResearch@ed.ac.uk if you have questions.

Clicking on the "agree" button below indicates that:

- You have read the above information
- You voluntarily agree to participate
- You are at least 18 years of age

☐ I agree. Begin registration.

Section One- School(s) Attended

1. What was the name of the therapeutic boarding school(s) you attended?

If you attended more than one, please state the names of each therapeutic boarding school you attended. Please note that NO contact will be made with the school(s).

Please state: (max one sentence)	Not sure	Prefer not to say
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2. Which state was the school in?

If you attended more than one, please select the state of the school you attended for the longest period of time. To be eligible to participate in this study, the therapeutic boarding school you attended must have been based in the USA.

Drop down menu	Outside of the USA*	Not sure	Prefer not to say
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*If selected a notification will pop up stating they are not eligible to participate.

3. What year did you first attend the school?

Drop Down Menu 1960- 1970 1971- 1980 1981- 1990 1991- 2000 2001- 2010 2011- 2015 2016- 2018	Not sure	Prefer not to say
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4. Approximately how long did you attend this school for?

Less than 1 month	2- 6 months	7 – 11 months	1 year	2 years
3 years	4 or more years	Not sure	Prefer not to say	Still attending*

*If selected a notification will pop up stating they are not eligible to participate.

5. At the time you were admitted to the school, what was your family's income?

High income	Low income	Other _____
Medium income	No income/ only income was government welfare provisions	Prefer not to say

6. Was the school you attended affiliated to a religion? If so, what religion?

Please state: (max one sentence)	No religious affiliation	Not sure	Prefer not to say
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7. Please click on each box to indicate how many of the following statements apply to the therapeutic boarding school you attended.

To be eligible to participate in this study, you must be able to confirm ALL of the following criteria.

I was a boarding student who slept on-campus	There was permanent on-site student accommodation, such	There was a peer group work component, often
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overnight, including most weekends	as student halls or dorms (NOT primarily camping in tents)	called 'group therapy'
School rules included limiting contact with family and/or friends outside the school	The school was aimed at accommodating teenagers who were considered to have mental health problems and/or substance misuse issues	There were at least five hours of taught classes on an average weekday

*All must be selected or a notification will pop up stating they are not eligible to participate. Contact information is provided if the participant wants to discuss eligibility.

Part Two- Your Background

8. What age are you now?

17 years old or younger *	18-24	25-29	30-34	35-39	40-44	45-49	50 Years or older	Prefer not to say
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*If selected a notification will pop up stating the participant is not eligible to participate.

9.What gender do you identify as?

Male	Female	Non-binary (someone who is not 'male' or 'female' may identify as non-binary)	Questioning/ not sure	Other _____	Prefer not to answer
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10. Do you identify as transgender or non-binary?

Yes, I identify as transgender or non-binary	No, I do NOT identify as transgender or non-binary	Questioning/ not sure	Other _____	Prefer not to answer
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11. What is your sexual orientation?

Heterosexual / Straight	Lesbian / Gay woman	Gay man	Bisexual	Queer ('queer' is a reclaimed term that refers to a range of sexualities that are not heterosexual/ straight)	Questioning / not sure	Other _____	Prefer not to answer
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12. Do you consider yourself to be disabled and/or Deaf?

Check all that apply.

- NO disability and NOT Deaf
- Chronic illness or health condition such as cancer, HIV, chronic heart disease, chronic fatigue/ME, diabetes
- Mental health difficulty or experience of mental distress, such as depression or anxiety
- Physical impairment or mobility issue, such as using a wheelchair or crutches or difficulty moving arms
- Blind or have a significant visual impairment
- Social/communication impairment such as a speech and language impairment
- Autism / Autism spectrum
- Specific learning disability such as dyslexia, dyspraxia or AD(H)D
- D/deaf or have a hearing impairment
- Neurodiversity, such as a cognitive, learning, or mental health diversity
- Disability, impairment, health condition or learning difference that is not listed above
- Prefer not to answer

13. How would you describe your race and ethnic background?

*Open ended question

14. Was your experience of therapeutic boarding schools generally positive, negative, or somewhere in between?

- Very positive
- Somewhat positive
- Neither positive or negative
- Somewhat negative
- Very negative
- Other _____
- Prefer not to answer

15. As far as you are aware, what was the main reason why you were admitted to a therapeutic boarding school?

*Open ended question

16. Are you currently affiliated with any therapeutic boarding schools or associations?

- Yes
- No
- Other _____
- Prefer not to answer

17. How did you come across this research study?

*Open ended question

18. Is there anything else you would like to add?

Note: There is a 500 character limit for responding to this question. The main opportunity to discuss experiences will be at the interview.

*Open ended question

Part Three- Interest in interview

19. If you are interested in being interviewed, the next page will ask for contact information. This is being asked so that the researcher can contact you to arrange an interview. This information will be kept secure and confidential.

- Yes, I would like to be interviewed. Continue to the next page.
- No, I do NOT want to be interviewed and do NOT want to share any further information. Finish the questionnaire.
- I am unsure. I would like to continue to the next page.

Part Four- Information for follow-up interview

20. What is your name

*Open ended question

21. Would you be interested in an interview in person, on the phone or over Skype?

Check all that apply. If you are invited to interview, this will be discussed in more detail.

In person	On the phone	Over skype
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22. If you are selected for an interview, contact in the first instance will be made via e-mail. Please state your preferred e-mail address for contact.

*Open ended question

23. If you are currently living in the USA, what state do you live in?

If you live outside of the USA, please indicate.

Drop down menu of USA states	Prefer not to say	I do not currently live in the USA*
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→ 27. * If a participant indicated they lived outside of the USA, the participant was routed to a question that asked which country they lived in. These participants would automatically skip questions 24, 25, and 26 and be sent directly to the final page.

24. Please enter a valid USA postcode for the area you currently live in.

*Open ended question

25. If you are comfortable with being contacted by phone, please provide your phone number and area code below.

*Open ended question

26. If contacted by phone, is it OK to leave voice mail or to send a text message?

- Yes, both voice mail and text messages are OK
- Yes, text messages only
- Yes, voice mail only
- No, please do not leave a voice mail or send any text messages

Closing page- Thank you for completing the questionnaire

Thank you. Your registration has been completed. If you are selected for an interview, I will contact you via e-mail in the first instance. You do not have to do anything further.

If you have any friends, family members, colleagues, or former classmates who may be interested in this research, please send them a link to the [Therapeutic Boarding School Research Study Website](#). Sharing the website on social media will further help contribute to the success of this research. You can also follow the study on Twitter @TBSResearch

If you have any questions, feedback or would like to withdraw your registration, please e-mail Sarah at TBSResearch@ed.ac.uk

If you are looking for emotional support, confidential support is available through the [Crisis Text Line](#). If you are in the USA, you can text them on 741741.

Therapeutic Boarding Schools: Narratives of Former Students

Interview Information Sheet

Purpose of the interview

Thank you again for completing registration; you are now invited to the second-stage of the research-- the follow-up interview. The interview is an opportunity for you to tell your own story of your time at a therapeutic boarding school. The aim of the research study is to provide insight into the experiences, perspectives, and narratives of former therapeutic boarding school students. I hope to interview people who have a range of backgrounds and experiences. Participation in the study is voluntary and you can choose not to participate at any point before, or during, the interview. You can decline this invitation.

What the interview involves

Interviews will be around an 1-2 hours long. Interviews can take place in person, over the phone or by Skype. There will be several questions but you do not have to answer anything you do not want to. If you are feeling unsure of what is expected, you can always ask me questions, either prior to or during the interview. You do not need to prepare in advance for the interview.

Ethical considerations

You can choose what you do and do not share in the interview. There is no pressure to discuss or describe anything you do not want to talk about. However, the research topic may bring up difficult emotions and memories. You may pause or stop an interview at any point. If you would like additional support after the interview, I will be available to discuss support options. The research has been approved by the School of Social and Political Sciences Board of Ethics, at The University of Edinburgh, Scotland.

Confidentiality

The interview will be audio recorded and transcribed. All interviews and transcriptions will be stored securely, according to UK research council security regulations, and your information will be kept confidential. Your personal information will NOT be shared with any outside institutions or individuals. In publications based on the research, all responses will be anonymous and any identifying information removed.

Who can participate

Anyone who met the criteria for the registration meets the criteria for the interviews. As a reminder, this is anyone who is 18 years of age or older, and has been a boarding student in at least one therapeutic boarding school in the USA. For the purposes of this research, a therapeutic boarding school is a residential school or academy aimed at teenagers who are considered to have mental health problems or substance misuse issues. They may also be known as 'emotional growth boarding schools.' The schools typically run 365 days a year, have on-site accommodation, have at least several hours of taught classes on an average weekday, and limit contact with family and peers outside of the school. If you do not meet these criteria or have questions about this please let me know.

Conflict of interest

The researcher has no financial, familial or personal investment in the therapeutic boarding school industry. The research is funded by the Economic and Social Research Council, a UK research funding organization that has no known connections to the therapeutic boarding school industry.

Access

If you require an interpreter, please let me know. If you plan to have someone accompany you to the interview, please confirm this with me in advance. Accessibility is important and if you have any requirements or questions, please contact me.

About the researcher

I am Sarah Golightley, a Social Work PhD student at the University of Edinburgh, UK. My background is in social work practice and mental health research. As a former therapeutic boarding school student myself, I aim to produce unique research on how former students describe their experience of therapeutic boarding schools.

Questions

If you have any questions, or would like more information, please contact me by e-mail at TBSResearch@ed.ac.uk.

Project Supervision and Contact

The project is being supervised by Dr. Autumn Roesch-Marsh, who can be contacted by e-mail at .

Chrystal MacMillan Building
15a George Square
University of Edinburgh
Edinburgh, United Kingdom
EH8 9LD

Therapeutic Boarding Schools: Narratives of Former Students

CONSENT FORM

YES / NO I confirm that I have read and understood the information sheet for the Therapeutic Boarding School Research Study and the researcher has answered any questions to my satisfaction.

YES / NO I understand that my participation is voluntary and that I am free to withdraw from the study, without having to give a reason and without any consequences.

YES / NO I understand that I can withdraw my data from the study at any time prior to December 31st, 2020.

YES / NO I understand that if I wish to be anonymous, any information recorded in the interview will remain confidential and no information that identifies me will be made publicly available.

YES / NO I consent to being a participant in this study.

YES / NO I consent to being audio recorded as part of the interview.

I agree to take part in the above study (PRINT NAME OR PSEUDONYM)	
Signature of Participant:	Date:

Appendix 4- Interview questions

BEFORE

- Can you tell me about where you grew up?
- How would you describe what you were like as a teenager? What was your family like?
- What was going on in your life before you entered a therapeutic boarding school?
- Why were you admitted? What did your parents know about the school? What did you know?
- How were you admitted? Was it voluntary?

DURING

- How would you describe the therapeutic boarding school? Building, campus, location, etc.
- What happened on a typical day in the school? How was your day organised? What happened on the weekends and on holidays?
- Do you remember any of the rules from the school? Communication, levels/stages, etc.
- What were the other students like? What were the staff like?
- Was there a form of group therapy? How would you describe the therapeutic approach?
- How long were you there for?
- What led to your leaving/graduating/being kicked out of the school?

* If more than one school:

- Why were you (re)admitted? How much time in-between? How would you describe this school? Was it different from the first one?

AFTER

- What happened after you left the school? What was life like?
- Do you think there were any long-term impacts of attending the school?
- Do you think anything could have improved your experience?
- Are there any changes you would like to see? Changes to policy, changes to family support.
- How do you feel about the school now? Has this changed over time?
- Overall, what is your impression of therapeutic boarding schools? How would you advise a parent who was considering sending their child to a therapeutic boarding school?

Appendix 5- Case study feedback outreach email

Subject: Therapeutic Boarding School Research Study

Hi _____,

I am Sarah Golightley, a doctoral researcher at the University of Edinburgh. Back in 2018, you participated in an interview for my PhD research on therapeutic boarding schools. First, I want to say thank you again for having spoken with me and for sharing what you have been through. I am aware this e-mail is reaching you several years later and that a lot has gone on in the world since we last spoke.

I am writing to let you know that I have chosen to include excerpts from our interview in one of the PhD chapters. Your name, the program you attended, and any other identifying information have been removed. The chapter focuses on institutional violence and the use of seclusion and restraint. I know these are difficult topics that can bring up a lot of emotions for people and could be triggering.

If you would like to read the case study in its current draft, I would be happy to send this to you. I would welcome any thoughts, feedback, or additional insights that you may have. I cannot guarantee to make every change that you suggest, but I will listen and try to take on board what you have to say. I want participants to feel that I have fairly described our conversations.

I hope to finish the doctoral dissertation soon and potentially publish academic journal articles based on the chapters. I am working to a deadline and require time to make alterations based on feedback, so **I ask that you respond to this email by March 6th, 2023, if you would like for me to send the draft case study to you.** If you confirm that you would like to read the draft, I will email this to you. I ask that you send any feedback within two weeks of receiving the draft document. If these timelines are not possible for you, please let me know.

You are also welcome to choose not to read the case study and to no longer engage in the research project. You are under no obligation to reply to this email. If I do not hear back from you, I will send one follow-up email and after this, I will assume you do not wish to hear from me.

I am happy to answer any questions you may have. We can also arrange a time to speak over the phone or via Zoom if this would be helpful for you.

Thanks again.

Kind regards,
Sarah Golightley