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To Stay or Not To Stay: Adolescent Client, Parent, and Counselor Perspectives on Leaving Substance Abuse Treatment Early

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Abstract

Increasing motivation and raising retention rates are considerable challenges for providers of adolescent substance abuse treatment. Research has shown that motivation for treatment, social influences (peers, family, counselors), and for some clients external pressure from the juvenile justice system, can serve as key factors in successful retention. To further understand influences on motivation and retention, focus groups were conducted in two residential treatment facilities. Adolescent clients, parents, and treatment staff were asked to describe their experiences with the treatment process focusing specifically on factors related to treatment attrition and retention. Qualitative data analysis revealed five themes affecting retention either positively or negatively. Themes included relationships (with family, peers, and counselors), responsibility (degree to which clients embrace jobs, roles, and rules), emotional regulation (ability to express feelings appropriately), thinking (identifying behavior patterns and recognizing consequences), and self-efficacy (feelings of empowerment). Implications for future research and for developing strategies aimed at increasing motivation and retention are discussed.

Keywords

Motivation for treatment; Retention; Adolescents; Substance abuse treatment; Qualitative analysis

According to a report published by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2011), over 10 percent of adolescents aged 12 to 17 were using illicit substances and nearly 1.8 million adolescents needed treatment. Yet for several reasons (e.g., not wanting to stop using, unaffordable cost, perceived negativity by others) over 90 percent did not receive treatment. Facilitating access to treatment and promoting retention among adolescents is urgent as those who complete treatment are two to three times more likely to have positive outcomes (Winters, 1999). Yet retention rates among youth have historically been low (Etheridge, Smith, Rounds-Bryant, & Hubbard, 2001; Pompei & Resnick, 1987). When clients drop out within the first few weeks, counselors have limited opportunities to promote change with their clients. Understanding the factors that impact motivation to stay in treatment may help to improve retention and address substance abuse problems in the United States.

Research examining attrition among adolescent treatment admissions has identified specific barriers to engagement, including low motivation and readiness (e.g., Melnick, De Leon, Hawke, Jainchill, & Kressel, 1997), lack of bonding with treatment staff (Battjes, Gordon, O'Grady, & Kinlock, 2004), dysfunctional family and peer relationships (e.g., Broome,

Simpson, & Joe, 2002; Gutman, Eccles, Peck, & Malanchuk, 2011), and juvenile justice involvement (e.g., Battjes, Gordon, O'Grady, Kinlock, & Carswell, 2003; Pagey, Deering, & Sellman, 2010). The purpose of this study is to further explore these relationships by soliciting information from counselors, parents, and adolescents regarding their experiences in the early days of residential treatment—in particular, their reflections on what promotes client retention or what incites them to leave prematurely. Qualitative analytical techniques are used to explore how experiences and perceptions of the treatment process impact retention. Input from three primary constituent groups may offer suggestions for future research and inform the development of interventions aimed at increasing retention among youth.

Motivation and Readiness

Perhaps the most commonly cited barrier to treatment retention (for both adults and youth) is lack of motivation (De Leon, Melnick, & Kressel, 1997; Melnick et al., 1997; Mensinger, Diamond, Kaminer, & Wintersteen, 2006; Orlando, Chan, & Morral, 2003). According to the Texas Christian University (TCU) Treatment Process Model (Joe, Simpson, & Broome, 1999; Simpson, 2004), motivation for treatment is a precursor to therapeutic engagement. Past research has shown that adult clients who are motivated for treatment are twice as likely to engage in treatment, and engaged clients are more than twice as likely to remain in treatment long enough to experience psychological and behavioral changes (Simpson & Joe, 2004). Similar relationships among treatment factors and improved outcomes have been found for adolescent populations (Joe, Knight, Becan, & Flynn, 2012).

But motivation to stay in treatment is highly complex and often erratic. It can be influenced or grow out of internal sources, external pressures, or a combination of the two (Battjes et al., 2004). The literature examining factors associated with retention of adolescents in substance abuse treatment has identified personal characteristics and external pressures, including family and peer influences, which can promote or hinder engagement. Specifically, adolescents with externalizing problems (Winters, Stinchfield, Latimer, Stone, 2008) including deviant behavior (Hawke, Hennen, Gallione, 2005; Winters, Stinchfield, Lee, & Latimer, 2008), frequent drug use (Battjes et al., 2004), and emotional issues (Battjes et al., 2004) generally have poorer treatment retention and outcomes. While higher severity of drug use (Slesnick et al., 2009) and deviant peer relations at admission (Broome, Joe, & Simpson, 2001) predicts higher motivation and readiness for treatment, failure to address these problems during treatment has been associated with continued association with drug-using peers (Harford & Muthén, 2000), development of substance abuse and dependence, and engagement in illegal activities (Grella, Hser, Joshi, Rounds-Bryant, 2001).

Interpersonal Relationships

Studies have shown that adolescents who perceived their counselor more positively are more likely to stay in treatment (Battjes et al., 2004). Additionally, when adolescents are paired with a therapist of the same gender, better therapeutic alliance and longer retention is reported (Wintersteen, Mensinger, & Diamond, 2005). Given that completing treatment leads to more successful outcomes (Simpson, Joe, & Rowan-Szal, 1997; Winters,

Stinchfield, Latimer, & Lee, 2007) and longer time in treatment improves outcomes for youth (Hser et al., 2001), efforts aimed at increasing motivation and counselor rapport have positive implications for treatment.

Other factors that can influence adolescent retention include relationships with family and peers (e.g., Harris, 2000). Specifically, family estrangement increases dropout (Winters, Stinchfield, Lee, et al., 2008). Indeed, when treatment is multi-faceted with an intensive approach involving family members, adolescents are more likely to stay in treatment for the prescribed length of time (Hogue & Liddle, 2009). Youth who complete treatment reported higher family alliance with the therapist than adolescents who drop out early (Robbins et al., 2008). When parents feel highly satisfied with a family night program and feel the topics are personally relevant, both adolescents and parents have higher participation in the program over time (Risberg & Funk, 2000). However, adolescents are more likely to drop out when a parent perceives the treatment as poorly organized and reports dissatisfaction (Luk et al., 2001). High quality family involvement appears to be an important ingredient for successful completion of drug treatment for adolescents.

Evidence for the role of peers in promoting treatment retention is sparse. The therapeutic community (TC) approach emphasizes the importance of peers in promoting retention, buy-in, and personal transformation (De Leon, 2000). But although peers are inherent in the TC approach, a study by Edelen and colleagues found that support from peers in treatment does not consistently predict retention. Rather, support from individuals outside treatment was influential (Edelen et al., 2007). Other studies document that deviant peers can initially be positive predictors of treatment readiness (Broome et al., 2001); however, when these associations continue after discharge, higher rates of relapse are reported (Broome et al., 2002). Clearly, these studies suggest the need to further explore the role of social factors (both within and outside treatment) in promoting treatment retention and motivation for change. Examining how these factors are perceived by adolescents will help providers better understand the link between interpersonal relationships and retention.

Juvenile Justice Involvement

In one study, external pressures from family, school, and juvenile justice to stay in drug treatment were not predictive of retention (Battjes et al., 2004) while in another study being involved in youth drug court increased retention (Pagey et al., 2010). Other research has found court referral to be a positive predictor of retention during the initial phase of treatment (Pompi & Resnick, 1987). These findings point to a need to further explore how adolescents perceive external pressures and how they impact their decisions to stay or leave treatment.

Current Study

Significant progress has been made in identifying barriers to treatment retention. But each of the afore-mentioned factors (motivation, interpersonal relationships, juvenile justice involvement) involve nuances that cannot be captured through large-scale, quantitative studies. Furthermore, the subtleties inherent in how youth think about their treatment experiences – how they feel about their transition into treatment, their progress, their

experiences within the treatment milieu and how these impact decisions to stay or leave – may or may not corroborate what the literature says about predictors of premature drop-out. Researchers have called for further studies to examine both adolescents’ and parents’ perceptions of treatment to better understand these subtleties and to help improve outcomes (White, Godley, & Passetti, 2004).

Using qualitative methods, we asked the individuals involved to share their own experiences and understanding of their decisions to stay or leave treatment. Specifically, when faced with the decision to stay or leave treatment, how does an adolescent client approach this choice? How do parents view the choices made by their child to stay or leave treatment? How do counselors understand the choices being made by their adolescent clients? This study explores factors that influence motivation for treatment– by asking the counselors, parents, and adolescent clients themselves to describe their experiences. By eliciting multiple viewpoints from those involved in the process, we sought to further examine and identify new perspectives on what promotes and/or interferes with motivation for treatment within residential settings.

Method

Procedure and Sample

Focus groups were conducted as part of a larger research project aimed at improving retention and engagement among youth in substance abuse treatment. During the initial planning phase, program administrators expressed concern over high client drop-out rates during the first 30 days of treatment. In their unlocked facilities (non-juvenile justice settings), clients were able to physically walk out of the facility or have a parent withdraw them from treatment against clinical advice. As a result, youth frequently talked about leaving during individual and group sessions and in informal settings with staff and peers. Administrators sought strategies and tools for counselors to use to encourage youth to remain in treatment and to improve motivation to stay. The focus groups were designed to help research and clinical staff understand the issue from multiple perspectives.

Two residential treatment programs were invited to participate. Programs were selected based on convenience (located within 40 miles of the research institution). All clients enrolled in residential services at each agency were invited to participate. Utilizing Krueger and Casey’s (2009) approach, we designed and carried out a total of five focus groups in May and October 2010. Group size, number of focus groups, and general structure of the sessions are outlined below. Both programs were located in large urban settings in the Southwestern U.S. Both were residential therapeutic communities where youth attended school, received individual and group counseling, and performed jobs related to the community (leadership roles, cleaning duties, assisting with food preparation, etc.). Length of stay could exceed 3 months, however, clients were generally expected to stay 28 to 40 days (allotted duration depended in part on funding availability). While clients were expected to remain on the premise for the duration of their stay, neither facility was gated or locked; thus, youth could “run” or leave against clinical advice if they chose. For most clients mandated to treatment by juvenile justice entities, leaving prematurely would result in juvenile detention. At both programs, off campus “passes” could be earned through

behavioral compliance. General program and client characteristics for 2010 are presented in Table 1.

At both programs, participants were recruited during weekly family sessions. Research staff informed clients and parents about the purpose of the study, that participation was voluntary, and that the proceedings would be kept confidential. Research assistants obtained written assent from youth and written consent from parents regarding youth participation from those that agreed to participate. At Program A, consenting parents were invited to attend a separate group session. At both programs, all staff with direct client contact were invited to participate. Written consent was obtained from all staff volunteers. Research methods and procedures were reviewed and approved by the University Institutional Review Board (IRB).

All families in attendance on the nights of recruitment chose to participate, and with the exception of one male client from Program B (discharged), all participated as planned. Three focus groups were conducted at Program A: one with adolescents currently undergoing treatment, one with parents, and one with treatment staff. The adolescent group included five boys and three girls, the parent group included two males and six females, and the staff group included two males and six females (which included counselors, case managers, and administrators). All clinical staff at the facility volunteered to participate. At Program B, two focus groups were conducted, one with six adolescent boys and one with five treatment staff (one male, four females in counselor and administrator roles). One clinical staff member declined participation due to a prior commitment. The parent group was not conducted at Program B due to scheduling constraints. Participant confidentiality was ensured by giving participants names of colors (e.g. Aqua, Sky, Ruby etc.), instructing them to refrain from using their given names, and encouraging them instead to refer to each other by the color name. The purpose of the study was conveyed to each participant at the beginning of the focus group. Each session lasted approximately 90 minutes and was audio recorded and transcribed.

A primary facilitator led each group, supported by a co-facilitator. Both were members of the research team and were trained in facilitating group discussion and maintaining fidelity of research protocols. The primary facilitator had over 20 years of experience as a counselor and research/training coordinator; the co-facilitator had over 25 years of experience in education and treatment research. The facilitator encouraged participation in all the groups by beginning with icebreaker questions and eliciting more information through follow up questions. In the adolescent focus groups, the facilitator began with broad questions including, "What do you like most about this program?" and "What is the hardest thing for you to deal with here?" Once participants felt comfortable expressing themselves, they were asked about staying versus leaving treatment: "When you have thought about dropping out of treatment, what makes you want to leave?" and "When you have thought about dropping out of treatment, what makes you decide to stay?" They were also asked, "What are some of the problems you see other teens having here at this program?" Discussion ensued, with all participants responding to prompts. The facilitator followed up with more specific questions, asking for clarification when needed. Parents were asked about their own experiences, including "What do you like most about the program?" and "What has been hardest for you,

in terms of having your child out of the home in a treatment program?” Parents were also asked about their adolescent’s experience (“When your child wants to leave or drop out of this treatment program, what do you think influences his or her wanting to leave?”), what the program could do differently (“How could this treatment program make it easier for teens to stay in treatment?”), and the parent’s role in encouraging retention (“When your child feels like leaving the program, what do you do or say to encourage him/her to stay the course?”). In the staff focus group, the facilitator began by asking “What do you like most about your role at this program?” Questions about why clients chose to stay or leave included, “What do you see teens struggling with the most when they first come into treatment?”, “When a teen client wants to leave or drop out of this treatment program, what do you think influences his or her wanting to leave?”, “How could this treatment program make it easier for teens to stay in treatment?” and “What do you see as the “secret ingredient” for motivating teen clients to stay?” All five focus groups had high participation from the members and minimal follow up questions were needed. These included “Could you expand on that?” and “Could you describe this in more detail?”

Data Analysis

Transcripts were analyzed following Garza’s thematic collation technique (Garza, 2011). Two primary readers read the transcriptions separately. The guiding questions for analyzing the data were “why do teens leave treatment early?” and “what keeps teens from running (leaving against medical advice) before they complete treatment?” The two primary readers demarcated places or moments in the transcripts that revealed the thinking and motivation behind adolescents’ decisions to stay versus leave treatment from the perspectives of adolescent clients, parents, and treatment staff. These moments comprised answers to the guiding questions above and included statements, phrases, or shifts in meaning from the transcripts. The moments were compiled into documents for the secondary reader to synthesize.

The secondary reader read the transcripts and reviewed the moments identified by the primary readers. She synthesized the two primary readers’ moments by eliminating redundancy, marking points of agreement and disagreement, and demarcating novel moments. Synthesis of moments was based upon a thematic cohesiveness whereby themes describe similar meanings. This reader examined both primary readers’ analyses and compiled a document that grouped similar moments together. For example, one primary reader identified a moment where an adolescent described seeking out a counselor to talk to while the other primary reader identified a moment describing a bond between an adolescent and counselor. The secondary reader synthesized these two observations by grouping them together, given that they both describe relationships with counselors. The document with compiled moments was then given to the tertiary reader.

The tertiary reader reviewed the compiled moments document (containing both the primary and secondary readers’ analyses) and indicated his agreement or disagreement with the analysis. All four readers then met to discuss the findings by resolving inconsistencies and developing consensus for the primary findings. Moments that thematically cohered were grouped together to comprise a theme. These collated themes were then compiled into a list

and all four readers independently identified the themes that each felt most exemplified adolescents' decisions to leave treatment. The group met to discuss observed themes, reach consensus on terminology, and identify two or three moments from the data that best exemplified each theme. The themes described are explicitly hermeneutic and comprise answers to the guiding questions above.

Results

The five themes identified included: 1) relationships, 2) responsibility, 3) emotional regulation, 4) thinking, and 5) self-efficacy. Each of the five themes is described on a leave/stay continuum to illustrate how the meaning shifts with regard to the decision to leave or stay in treatment (see Figure 1). Each theme is further divided into three sub-themes illustrating personal, treatment, and external dimensions that influence decisions to leave or stay. The personal dimension comprises individual issues (including internal motivations and thought patterns), the treatment dimension comprises areas related to the realm of treatment (including peers, programming, and structure), and the external dimension comprises those outside the treatment program (including obligations and consequences from the juvenile justice system and family).

Theme 1: Relationships

Relationships that adolescents have with others, either inside or outside the treatment environment, can impact the decision to leave or stay. These relationships can serve as positive factors that keep them in treatment or as negative factors that pull them out of treatment.

Personal—Adolescents consistently expressed that family and friends are highly influential in their lives, and described how treatment places a strain on these relationships. One adolescent client described, “I want to be with my family ‘cause I haven’t been with them in like so long that sometimes I want to leave so I can just be with them.” Others described wanting to stay, saying, “But when I think about leaving ...it’s well my family, how they would feel if I just gave up.” They described feeling conflicted by a tug and pull – missing friends and family while in treatment and yet not wanting to disappoint or let their loved ones down by leaving or running. For some adolescents, it appears that obligations at home pull them out of treatment as they feel responsible while they are away from home. Counselors stated that some adolescents feel their obligations and responsibilities at home do not get taken care of while they are away and can pull adolescents out of treatment.

Treatment—Adolescents indicated that the bonds they formed with peers and counselors in treatment influenced their decisions. One adolescent provided insight into these decisions, saying, “I didn’t want to go but I already told him [another client] I gotta get out you know, I couldn’t look back on it, I already shook his hand.” Some bonds strengthened their resolve to stay while other associations promoted decisions to leave. Adolescents commiserated with their peers, sometimes discussing and planning escapes, while other times peers provided support to clients who are thinking about leaving. Counselors stated that youth often run in groups, planning and executing their decisions to leave together. Even in the

face of consequences, the bonds formed among peers in treatment appear to be strong and influential in adolescents' decisions. Some of the adolescents described taking on the roles of a 'big brother' or 'big sister' to their peers and relating similar experiences to encourage them to stay. Bonds were also forged with staff members who provided a listening ear, encouraged personal accountability, and supported them as they worked toward recovery.

External—For many adolescents, the decision to stay or leave occurs in the context of family pressures. While adolescents feel a pull from family, parents describe difficulties in providing support. One parent relayed how he talked his son into staying in treatment: "Son, I love you but I can't [come and get you] because if you run now, you'll run the rest of your life." Parents sought to be involved in their child's treatment, supporting treatment staff, even if that meant tough love. But at the same time, parents struggled with wanting to "rescue" their child. Sometimes, parents held on too tightly not allowing their child the chance to recover. One counselor illustrated this issue, stating that some dyads are "so connected that it is almost like removing an arm from mom to get that kid in treatment." Some parents described feeling torn, viewing treatment as difficult for their child but also seeing treatment as good for the long-term.

Parents generally expressed a desire to be more involved in the treatment process. They struggled with their new role and the realization that they cannot always help their child. Relinquishing primary responsibility and care to the treatment facility appears to be difficult, especially when they are uncertain what to expect regarding treatment regimens and their role in supporting recovery efforts. A recurring theme among parents involves balancing the desire to give in to their child's pleas to leave treatment and the desire to be firm, unyielding, and supportive of intervention efforts. Counselors acknowledge the difficulty parents have in balancing these two opposing desires, citing concerns that counterproductive involvement on the part of parents often results in early dropout because they more often concede to their child's plea to leave.

Theme 2: Responsibility

The decision to stay or leave treatment appears to be tied to one's willingness to accept consequences for one's actions. When youth come face to face with their problems in treatment they either accept and acknowledge responsibility or attempt to flee and escape.

Personal—During the course of treatment, adolescents are faced with the question of accepting personal responsibility. One adolescent described how the treatment process fostered his ability to take responsibility for personal decisions, "Like you have to get a job here and maintain that job and hold your peers accountable and everything makes sense in here, cause in the outside world somehow, some way like it's gonna remind us of hey, you did that in there – so I can handle this 'cause I've already done it." Adolescents described a struggle between owning one's choices and accepting responsibility for the consequences versus distancing oneself from one's choices. They related how they initially avoided responsibility, refusing to work or put any effort into their own lives. During the course of treatment, a transformative reversal occurred whereby they learned to be accountable to peers and to themselves. Faced with the ownership of one's actions, adolescents appear to

either flee from responsibility by leaving treatment or embrace responsibility by staying. One parent described a transformative process as her son began embracing his personal choices, “While he has been in here he has been accepting more responsibility, not just for himself but to hold others around him accountable. That is the first time I’ve seen it from him.”

Treatment—The treatment process itself provides opportunities for the adolescents to accept responsibility. One staff member expressed that clients “become responsible for each other in that sense and it is really neat to see ...these little gangbangers, these nasty little kids that walk in here and they are sitting in a group going ‘dude, I’m worried about you.’” This transformative process of beginning to embrace responsibility is illustrated in the treatment environment where adolescents learn to care for each other and to express themselves appropriately. The adolescents begin to be accountable to their peers in treatment by serving as examples, fulfilling their obligations and jobs at the facility, and providing a reflective mirror in which to view each other. Peers point out when another adolescent is not pulling his/her weight or not doing his/her job which entices some into action. For those who have difficulty facing responsibility or accepting accountability for their actions, fleeing the treatment facility appears to serve as an escape back to a world where they did not have to face consequences.

External—For some adolescents, fulfilling obligations with the juvenile justice system keeps them from leaving the facility. Staying offers a shorter time commitment with fewer unpleasant obligations for adolescents in this situation. Faced with the possibility of juvenile detention, some adolescents seem to prefer the ‘misery’ of the treatment facility compared to the anticipated fear of a detention facility.

Theme 3: Emotional Regulation

The decision to stay or leave treatment also arises in the context of affect. Adolescents describe wanting to avoid negative feelings and pursue pleasurable feelings, which shape their understanding of and reaction to the treatment process.

Personal—Adolescents vary in their ability to deal with both negative and positive emotions that arise. Ideally, adolescents learn to identify emotions, express them appropriately, and monitor themselves through the course of treatment. One parent described her son’s emotional reaction to structure, “When he first got here, his attitude was good, he was happy to be here when I checked him in. But in a week, he’s like ‘this is crap. I’m not staying. I’m going to get out of here as soon as I can’ and he crawled through the window and made it back to the house.” Throughout treatment, many struggle with anger and their reactions to it; some shut down and close themselves off to the world, while others are prone to inappropriate outbursts. When faced with uncomfortable negative emotions, some leave treatment seeking an escape and attempt to return to their life with drugs that brought them pleasure (if only fleeting and superficial).

Treatment—Some adolescents resist and oppose the structure they feel treatment imposes upon them. As one counselor stated, “the first time they are told NO, first time they are

given something they don't want to do, that is when we start seeing [the real] them." Agitated and uncomfortable, the adolescent clients fight back against the rigid schedule and their inability to do what they want when they want. Leaving the facility appears to offer a refuge from the brick wall that separates them from freedom. Working through these emotions with counselors, some adolescents begin to embrace their feelings and accept responsibility, learning to regulate the emotions they are feeling. While they may still resent the structure, they learn to express their anger in socially acceptable ways. They no longer perceive the structure of treatment as a barrier, but rather as a pathway towards their goal of successfully completing treatment.

Theme 4: Thinking

The decision to leave or stay in treatment is shaped by how the adolescent and parents think about the reasons for being in treatment and their recognition of a problem.

Personal—Decisions to leave treatment often appear to be predicated on clients' poor problem recognition and a lack of concern for rules. Staff members related that some clients "just don't care about rules. They just don't care that it is illegal. They don't care about the trouble they are going to get in." Many adolescents appear to selectively ignore problems they have, and some would rather leave treatment than admit they have a problem. Conversely, some described how treatment is enlightening with regard to their problems; "I know what happens, I know why I use, I crumble under anxiety and things that happen." When adolescents recognize the source and/or extent of their problems, treatment is viewed as an opportunity to address them.

Treatment—The treatment process also impacts a client's willingness to acknowledge his/her problems and accept responsibly for his/her actions. One adolescent expressed how clients gain insight into their own actions, "they're like 'dang I really need to change because I wonder how many people like I've hurt in the past doing that.'" Adolescents who do not see the connection between actions and consequences fail to recognize their problems and toy with the idea of leaving. Witnessing many other clients return from running episodes, they may get the impression that they are immune from negative consequences. Likewise, the bonds that form between peers can influence feelings of immunity and erroneous thinking about the consequences of leaving. The treatment experience also helps them identify consequences to leaving or deciding to stay.

External—External factors such as dysfunctional thinking and maladaptive behaviors among family members also appear to affect adolescent thinking regarding decisions to leave or stay in treatment. One staff member expressed how some parents do not acknowledge that their child has a problem, "it is hard for them to go out there [world outside of treatment] and be successful because mom is going to allow those [same maladaptive] behaviors." Without insight into their child's problems, some parents enable these behaviors and allow dysfunctional patterns to continue. As a result, these adolescents appear to leave treatment in order to return to their parentally endorsed lifestyle.

Theme 5: Self-efficacy

The theme of self-efficacy, or the belief that one can complete treatment, arises in conjunction with the decision to leave or stay in treatment. This concept is underscored by some underlying problems that adolescents bring into treatment, including guilt, anger, and anxiety.

Personal—Parents and counselors described how some adolescents ruminate on past mistakes and become frozen and unable to move forward. Unable to forgive themselves, the adolescents appear have difficulty envisioning a future where they are unburdened by their past. One parent stated, “if he looks in the mirror and sees something he doesn’t like, then he is going to need to change it and some people will turn that into I’ve got to work harder, I’ve got to pray harder, whatever and other people will turn well all I’ve got to do is get high.” Staying in treatment can provide an opportunity to gain self-respect and feel hopeful about the future. However, through the treatment process adolescents are confronted with their past mistakes and personal tendencies that they may not like about themselves. Leaving treatment offers solace from having to reflect on past mistakes. By staying in treatment, some adolescents begin to recognize their problems, see the consequences of their actions, and become empowered in their own lives as they see themselves increasingly as an impactful agent in their own world. As one counselor stated, “they start to get that attention in a positive way, either a report card or you know they get what they call push-ups [compliments] and stuff like that and they start to feel good about themselves and they want to feel that more often so they start to do more and more things to please the staff, please their parents.”

Treatment—Facility programming can also influence self-efficacy. Counselors described how they try to encourage their clients by giving compliments and words of praise with one stating, “They would rather be here because it is stable and it is predictable. You know, you can be a butt and we are still going to care about you. The safety, the security of being here.” This feedback can instill confidence in those who do not recognize positive qualities in themselves. Treatment offers adolescent clients an opportunity to see oneself in a new light, to identify positive attributes, and develop skills to make positive changes. Counselors stated that some clients do not want to leave the facility after successful completion because it is the only place that welcomes and accepts them. “For some, this positive feedback appears to be difficult to accept; not only is it foreign, but it may be unwanted. Leaving treatment offers an escape back into a familiar life.

External—Often, parents express a lack of hope for their child, highlighting the need for positive influential relationships. The adolescents invoke the importance of their parents’ support many times in their decision to leave or stay in treatment. However, when the parents themselves do not see their child successfully completing treatment, the adolescent may see no point in staying. Parents expressed feeling “out of the loop” and “in the dark” with regard to their child’s progress in the program, and this ignorance could potentially translate into a lack of providing hope and support for their child.

Discussion

Summary and Conclusions

Great strides have been made toward identifying barriers to treatment retention among adult and adolescent populations. However, there are gaps in our understanding of how and why these barriers (lack of motivation, dysfunctional relationships, poor therapeutic relationships, and criminal involvement) affect decisions to stay or leave prematurely. As data from the current study suggest, relationships between “barriers” and retention decisions are not always direct or unidirectional. Our qualitative analysis reveals that they are complex, and each theme can serve as both a hindrance or support for staying or leaving. Our study illustrates how these barriers are lived and experienced by those involved in the treatment process and reveals how factors related to motivation to stay or leave depend, in part, on how the individual values and interprets them. Findings from the current study shed new light on literature that cites the importance of being motivated and ready for treatment (e.g., De Leon et al., 1997). While none of the participants mentioned motivation specifically, they describe specific people, experiences, thoughts, and frustrations that they feel directly impact decisions to stay or leave. Adolescents, parents, and treatment staff in this sample generally expressed that relationships, responsibility, and emotional regulation are paramount, and decisions to leave or stay are further influenced by thinking about consequences of actions and self-efficacy toward staying in treatment. Results also suggest that these motivational elements arise within three dimensions of influence: personal, treatment, and external. For some individuals, the personal dimension may be most salient; for others, the external influences or treatment dimensions may be more prominent. Furthermore, the salience of each dimension and the complex multifaceted links between them are likely to change depending on the client’s own values and experience which may be further influenced by contextual factors surrounding their current circumstances.

Consistent with prior literature focusing on relationships as barriers to treatment retention among youth, the most prominent theme identified in this study involves the importance of relationships. Adolescents, counselors, and parents each emphasize the role of family and peers, both in keeping youth in and pulling them out of treatment. Adolescent clients describe how having staff members and friends in treatment (that they could relate to and trust) strengthens their resolve to stay. However, they also describe a tug and pull from both peers external and internal to the treatment context and family. Peer pressure to run and missing friends and family often entices them to leave treatment, and sometimes well-meaning family members can interfere with retention efforts. Previous literature corroborates the importance of building close supportive relationships with counselors (Battjes et al., 2004) and friends and family (e.g. Winters, Stinchfield, Lee, et al., 2008) to help improve retention. This study illuminates the subtleties around how relationships influence adolescents’ motivation to stay in treatment.

Involvement in the juvenile justice system was acknowledged by all three groups as important in the decision to stay or leave treatment in the context of responsibility. For some juvenile justice-involved clients, the fear of juvenile detention was an incentive to stay in treatment; however, these adolescents were choosing to stay to avoid less desirable

alternatives. They may have been willing to embrace job-specific responsibilities or at least “go through the motions,” but not yet willing to accept responsibility for their personal choices that led to drug use and illegal involvement. Further exploration of the degree to which personal responsibility is internalized among juvenile justice-involved youth could potentially shed light on the inconsistent relationship between juvenile justice and retention found in the literature (Battjes et al, 2004; Pagey et al., 2010). For youth who embrace responsibility for their actions, transformation and progress towards recovery can begin.

In addition to traditionally cited barriers, results from this study suggest additional areas of influence, namely emotional regulation, thinking, and self-efficacy. Treatment offers an occasion for positive and negative emotions to surface in a structured, supportive environment. Learning to understand and express emotions in appropriate ways is a critical component of development and a focus of treatment that can directly impact retention. For instance, difficulty controlling intense emotions that arise in reaction to structure, rules, or provocation by peers (i.e., explosive outbursts) can lead to rash decisions to leave treatment. Related to emotional regulation is the ability to think objectively about personal issues – identifying consequences of personal choices, recognizing negative behavior patterns, and so forth. The degree to which youth are willing to think differently about their situation and personal issues affects retention in positive ways. As adolescents begin to recognize behavioral patterns and internalize new strategies for solving problems, they describe feeling greater motivation for change. Practice with new skills, both in regulating emotions and in thinking objectively, contributes to greater self-efficacy, which also appears to influence their commitment to treatment. As they experience success, they begin to envision a hopeful future where they are able to make positive, productive choices. Together, these impact willingness to be in treatment and a desire to change. When confronted with responsibility, recognition of the problem, and a flood of emotions, treatment is often viewed negatively and the adolescent seeks to avoid these issues by fleeing the situation. Understanding these issues surrounding the decision to leave or stay in treatment may be crucial to improving retention efforts.

Limitations

Results offer insight to the perspectives of adolescent clients, parents, and staff on issues related to treatment retention. The in-depth analysis of focus group transcripts provides researchers and clinicians a better understanding of how various issues arise in the programs and how treatment staff, adolescents, and parents think and feel about these issues. Consistent with limitations associated with qualitative studies, the sample size was small, but allowed sufficient opportunity to explore the complex issues surrounding the decision to leave or stay in treatment. Additionally, it should be noted that programs were chosen based on convenience, participants were drawn from only two residential treatment programs, and females were underrepresented. Results may not generalize to adolescents in other treatment modalities or enrolled in programs in other regions. Furthermore, demographic and length of stay data are available only for the population of clients receiving treatment at that agency, not on specific individuals who participated in focus groups. Focus groups were conducted with youth who were currently in treatment, including some adolescents who had run and returned, but specific details regarding attempts to leave treatment prior to the focus groups

were not elicited. . Finally, information about severity of use and receipt of medication-assisted treatment (e.g., methadone, buprenorphine, Naloxone) was not collected.

Directions for Future Research

Given that recent research indicates the efficacy of medications for improving retention among youth (Woody et al., 2008), future studies should examine whether medication therapies also impact relationships and personal responsibility during treatment. Other avenues for future research include the use of mixed methods designs that identify qualitative themes, such as those identified here, and then develop measures to assess them quantitatively. In particular, more research is needed to further understand the complexity of relationships with both family and peers. Studies addressing the role that juvenile justice serves as a source of external pressure are needed, particularly with regard to the internalization of personal responsibility. Additionally, further work is needed to explore the inter-relationships among emotional regulation, the application of new thinking strategies, and self-efficacy and their implications for retention among youth. Because comparisons on types of treatment approaches are not possible with this data, future research should also investigate which elements of treatment, including evidence based practices, are most effective and the best at retaining clients. As we did not collect data on past running attempts, interviewing youth who run and do not come back could provide an avenue for future research.

When clients engage through higher participation and better therapeutic relationships, they are more likely to remain in treatment (Joe et al., 1999; Simpson, 2004). Motivation is a complex phenomenon, especially among adolescents who are still maturing both physically and emotionally and who rely heavily on peers as a source of information, support and validation. It is therefore important to administer induction activities that raise motivation, readiness, and responsiveness to primary treatment (McWhirter, 2008).

Innovative activities implemented in the early weeks of treatment that provide opportunities for adolescents and counselors to explore personal issues and develop effective coping and thinking strategies are needed in order to effectively increase retention in residential treatment. Activities that provide opportunities for structured peer interaction and cooperation may be particularly useful in decreasing negative peer influences and increasing peer support for treatment. Involving parents in the process by providing an overview of treatment and a description of what to expect throughout treatment might facilitate positive and effective external support from parents. Furthermore, efforts aimed at helping youth restructure their thinking (for example, reframing “missing one’s family” as “earning respect of family by completing the program”) might prove useful in keeping them in treatment. The challenge for providers is to design and implement strategies that help youth and families recognize which themes or issues are most salient for the client and address how to move adolescents from the negative “leave” end of the leave-stay continuum toward the positive “stay” end.

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Figure 1.
Why youth leave or stay in treatment: Compilation of themes expressed by adolescent clients, parents, and counselors.

Table 1

General Program and Client Characteristics for 2010

	Program A	Program B
Client Capacity	28	16
Average Length of Stay (days)	41 (0-173)	38 (3-75)
Age (years)	15.7 (13-17)	15.0 (13-17)
Male	77%	100%
Race/Ethnicity		
Caucasian	30%	80%
African American	14%	20%
Hispanic/Latino	51%	52%
Mandated to treatment [*]	35%	100%
Primary Problem Drug	Cannabis	Cannabis
Met Criteria for Drug Dependence	65%	88%
Successful Treatment Completion ^{**}	35%	68%
Average # Leaving (each month)		
Against Clinical Advice	6.5	3.0
Prior Treatment Experience ^{***}	71%	Not Available

^{*} By probation, drug courts, or juvenile justice agencies

^{**} Criterion for Program A = 45 days or longer; Criterion for Program B = 41 days or longer

^{***} Data from 2011 (not available for 2010)