Residential Treatment for Children & Youth

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/wrtc20

# "More Than Just a Therapist": Psychotherapist Perspectives of the Impact of Boundary-Setting on Therapeutic Alliances in Youth Residential Treatment Facilities

Charis Stanek

**To cite this article:** Charis Stanek (01 Apr 2025): "More Than Just a Therapist": Psychotherapist Perspectives of the Impact of Boundary-Setting on Therapeutic Alliances in Youth Residential Treatment Facilities, Residential Treatment for Children & Youth, DOI: 10.1080/0886571X.2025.2484220

**To link to this article:** https://doi.org/10.1080/0886571X.2025.2484220



Published online: 01 Apr 2025.

RESIDENTIAL TREATMENT FOR CHILDREN & YOUTH
https://doi.org/10.1080/0886571X.2025.2484220

Routledge
Taylor & Francis Group



# "More Than Just a Therapist": Psychotherapist Perspectives of the Impact of Boundary-Setting on Therapeutic Alliances in Youth Residential Treatment Facilities

Charis Stanek

College of Social Work, The Ohio State University, Columbus, Ohio, USA

**ABSTRACT**

Although it is widely known that therapeutic alliances are important for client outcomes, less is known about how to foster a strong therapeutic alliance between psychotherapists and youth clients in residential treatment. Therapeutic alliances depend on appropriate psychotherapist-client boundaries; however, psychotherapist boundaries with youth clients are complicated by residential settings due to psychotherapists navigating many roles. This paper explores psychotherapists' perspectives on adhering to the following psychotherapist boundaries outlined by the American Counseling Association Codes of Ethics: dual roles, psychological separateness, and therapist neutrality. Interviews were conducted with 10 psychotherapists and coded using thematic content analysis. Results suggest that these types of boundaries are challenged with youth clients in residential treatment; however, psychotherapists shared mixed opinions on the impact of not adhering to the aforementioned boundaries on their therapeutic alliances with youth clients. Psychotherapists within state-funded facilities compared to private facilities mentioned additional challenges to boundary-setting and building therapeutic alliances with their youth clients. State-funded facilities have fewer concrete resources, greater youth client needs, fewer staff, and staff with less training, resulting in psychotherapists taking on more roles to supplement these gaps. Findings warrant further investigation of evidence-based best practices on boundary-setting among psychotherapists in youth residential treatment facilities.

**Practice implications**

- Therapists have mixed perspectives and practices on boundary-setting in youth residential treatment facilities.
- Lack of resources and trainings may contribute to differences in boundary-setting and the strength of therapeutic alliances between agencies.
- Guidelines on appropriate boundary-setting and techniques for strengthening therapeutic alliances in youth residential treatment facilities are warranted to improve outcomes.

**KEYWORDS**

Residential care; youth; therapy; boundaries; therapeutic alliance; dual roles

**CONTACT** Charis Stanek stanek.64@buckeyemail.osu.edu College of Social Work, The Ohio State University, 1947 N College Rd, Columbus, Ohio 43210, USA

## Introduction

Youth residential care has long been critiqued for poor longitudinal youth outcomes (Gutterswijk et al., 2020; Strickler et al., 2016). A known predictor of client outcomes is appropriate boundary-setting (Asnaani & Hofmann, 2012; Campos-Ramos, 2016; Herlihy & Corey, 2015), which refers to the limitations that the psychotherapist establishes with their client to assure that the therapeutic relationship, also known as the therapeutic alliance, is protected, or in other words, that the relationship allows for effective client engagement in treatment (Reamer, 2020). Yet, in youth residential facilities, traditional boundary-setting with youth clients may be blurred as psychotherapists are asked to take on additional care-taking roles (e.g., mentoring, disciplining) (Gallant, 2003; Kendrick, 2013), potentially resulting in boundary crossings, defined as "departures from an established treatment framework" (e.g., multiple points of contact, contact outside of the office) (Glass, 2003). In some contexts, boundary crossings are necessary for the treatment plan (Zur, 2007); however, it remains unclear in the literature what types of boundary crossings are permitted and/or encouraged between psychotherapists and their youth clients in residential treatment. This is important to understand given that boundary crossings can subsequently interfere with youth treatment by potentially disrupting the therapeutic alliance (Coady, 1993), known as an alliance rupture (Safran & Muran, 2000). Despite the importance of the therapeutic alliance on outcomes (Baier et al., 2020), little is known about boundary-setting, therapeutic alliances, and alliance ruptures in the context of youth residential treatment (Duppong Hurley et al., 2017).

The therapeutic alliance, which is "the observable ability of the 'social worker' and client to work together in a realistic, collaborative relationship based on mutual liking, trust, respect, and a commitment to the work of counseling" (Coady, 1993), is crucial in all therapeutic settings for youth given it is tied to their clinical outcomes (Roest et al., 2023a). A therapeutic alliance is comprised of three major components: 1) the therapist-client bond, 2) mutually developed goals, and 3) co-determined therapeutic tasks (Bordin, 1979). To date, research on therapeutic alliances has focused on adult treatment (Elvins & Green, 2008) but has shown that therapeutic alliances are also influential for youth outcomes (Green, 2006). One systematic review and meta-analysis found that adolescents receiving psychotherapy had better treatment outcomes (e.g., lower symptom severity, higher global functioning, and reduced emotional distress) when they reported stronger working alliances (Murphy & Hutton, 2018). It is important to understand the nuances of therapeutic alliances between psychotherapists and youth clients given youth may have different perceptions of this construct (Roest et al., 2023b; Shirk et al., 2010). Therapeutic alliances can also look different based on unique client needs (Gelso et al., 2018) and there are many additional considerations

for boundary-setting and therapeutic alliances within the context of youth residential care that have gone largely unacknowledged (Bunner & Yonge, 2006).

Although less is known about therapeutic alliances between psychotherapists and youth clients in youth residential treatment, there is still evidence pointing toward the importance of strong therapeutic alliances in these contexts for youth outcomes (Duppong Hurley et al., 2017; Florsheim et al., 2000). One study found that reports of stronger therapeutic alliances with youth were predictive of better emotional and behavioral outcomes (Duppong Hurley et al., 2017). Another study among adolescent boys in a residential program found that a stronger therapeutic alliance measured 3-months into treatment was linked to improvements in mental health as well as reduced rates of recidivism (Florsheim et al., 2000). Furthermore, stronger therapeutic alliances among this population have also shown to impact treatment motivation (Roest et al., 2016), which subsequently influences treatment outcomes (Olver et al., 2011). Given this role of the therapeutic alliance in this population, it is important to understand the potential impacts on the therapeutic alliance between psychotherapist and youth in residential treatment.

There are potential benefits to the therapeutic alliance between psychotherapists and youth clients within the residential context. According to Miller et al.'s four-factor process model, extra-therapeutic factors play a huge role in the therapeutic process (Miller et al., 1997), contributing up to 40% of treatment outcomes (Sprenkle & Blow, 2004). An extra-therapeutic factor important to youth outcomes in residential treatment is the milieu, often referred to "milieu therapy" (Roehrle & Strouse, 2008), which is the therapeutic routine and atmosphere being constructed by direct care staff outside of the context of individual, group, and family therapy (Smith & Spitzmueller, 2016). Considering youth in residential care spend a majority of their time in the milieu, this residential setting provides an opportunity for youth residential staff, including psychotherapists working a shift within the milieu, to strengthen their therapeutic alliances with youth clients through increased engagement with youth, trauma-informed care practices, and use of nonviolent resistance (Roest et al., 2022). Additionally, when clients have fewer extra-therapeutic resources, such as limited social support when living away from family, friends, and their home community, the therapeutic alliance can have a stronger influence on client outcomes (Zimmermann et al., 2021). Given limited social support is commonly found among youth in residential treatment (Ferreira et al., 2020), the extra time spent with psychotherapists in the milieu setting could potentially strengthen therapeutic alliances between psychotherapists and youth clients, and subsequently impact treatment outcomes. However, there are significant gaps in the existing literature on how the milieu affects relationships between psychotherapists and youth in particular and if this additional exposure to youth benefits therapeutic alliances between

psychotherapists and youth in residential treatment (Brendtro, 2017; Harder, 2018; Smith & Spitzmueller, 2016).

Despite these potential assets of the residential environment in cultivating strong therapeutic alliances, previous literature also alludes to potential risks to building therapeutic alliances, as well as alliance ruptures, in residential settings (Byers & Lutz, 2015; Shechory & Sommerfeld, 2007). These include limited trust from youth that have been neglected, clients with more aggressive behaviors and lower commitments to therapy, and challenges for the youth in adjusting from being away from home (Byers & Lutz, 2015; Shechory & Sommerfeld, 2007). Additionally, the environment itself and the institutional factors within residential treatment that dictate a youth's treatment pathway may also cause strain on therapeutic alliances being formed (Byers & Lutz, 2015). These factors include 1) strict rules and regulations that can frustrate the youth, 2) limited confidentiality which can discourage youth from being vulnerable, and 3) interpersonal conflict within the residential environment that can diminish youths' feelings of comfort or safety (Byers & Lutz, 2015). Staff in residential facilities can also complicate the therapeutic alliance due to limitations in their training, as well as experiences of burnout, which can dampen their capacity to provide emotional support (Bickle, 2021).

It is well known that appropriate boundary-setting strengthens therapeutic alliances in out-patient settings (Baier et al., 2020), but this has yet to be explored in youth residential contexts. Therapist-client boundaries are defined as "the set of rules that establishes the professional relationship as separate from other relationships and protects the client from harm" (Mathews & Gerrity, 2002). Deviations from traditional models of psychotherapy (e.g., in-office only, no physical contact, no self-disclosure) would constitute a boundary crossing (Zur, 2007), which should only occur with clinical intention. Both milieu staff and psychotherapists in residential care can form therapeutic alliances with youth (Byers & Lutz, 2015) and provide a secure base for predicting positive youth outcomes (Harder et al., 2013). Yet, the role of the psychotherapist in milieu therapy and how that may differ from a milieu staff member is undefined. Psychotherapists play a crucial role in youth residential treatment facilities, given the primary goal of residential treatment is to improve the mental and behavioral health outcomes of youth and psychotherapists play a lead role in their treatment planning.

Psychotherapists in youth residential facilities are obligated to adhere to the same code of ethics as psychotherapists working in private practice unless there is therapeutic or legal justification for veering from these set standards (Pietz & Mattson, 2014). The boundaries discussed in this study, which may pose unique complications by a residential environment, include dual relationships, psychological separateness, and therapist neutrality. These specific boundary definitions are grounded in the American Counseling Association Codes of Ethics (Ponton & Duba, 2009) and inform best practices for all

psychotherapists, including those working in youth residential treatment facilities. Dual relationships are defined as any other type of relationship between a psychotherapist and client (e.g., friend, coworker, family member, sexual partner) that can interfere with their therapeutic work (Reamer, 2020). Psychological separateness is defined as a client independently functioning mentally and feeling a sense of agency, autonomy, and self-determination in their treatment (Simon, 1992). Lastly, therapist neutrality is defined as remaining neutral and uninfluential regarding a client's personal life choices (Gutheil & Brodsky, 2011).

Given that many youth in residential care are wards of the state, all staff members, including psychotherapists, are responsible for the child's protection and safety, which involves some degree of control or discipline to maintain safety on the unit (Gerber, 2019). For many youths during residential treatment, the state has formal caretaking responsibilities for them, known as corporal parenting (Courtney, 2009). It is important for residential staff to fill gaps in disciplining and caretaking as they temporarily and collectively subsume the role of the caretaker. This caretaking is also crucial considering residential staff are operating within a group setting which adds the potential threat of group conflict; thus, youth behaviors need to be monitored and addressed for safety reasons (Kahan, 1994). While staff working in group care settings with youth must take on parenting qualities for the sake of the child's development and safety, the literature does not clarify if this includes psychotherapists (Kahan, 1994). Nonetheless, it is important to consider how psychotherapists' disciplinary actions can result in a boundary crossing of "dual roles." Previous research within correctional facilities has shown that dual relationships can be helpful when clients perceive them to be fair, respectful, and driven by kind intentions (MacCoun, 2005). However, youth in residential treatment have also expressed difficulties with their relationship to their therapist when psychotherapists are rigid about program rules or place too much pressure on youth to accomplish tasks or behave a certain way (Manso et al., 2008). Thus, it is important to consider the implications that this role-switching can have on therapeutic alliances between psychotherapists and youth clients in youth residential treatment (Morán et al., 2019).

Additionally, as psychotherapists take on parental attributes in their clients' lives, they may possibly limit a youth's sense of autonomy which can impair collaboration between youth and psychotherapists (Michaud et al., 2015), potentially resulting in a boundary crossing of "psychological separateness." Ryan and Decy's self-determination theory (SDT) explains that autonomy, competence, and relatedness are all necessary elements to individuals' motivation and mental health (Ryan & Deci, 2000). Youth residential facilities can face challenges in promoting self-determination, and subsequently their psychological separateness, due to repressive practices by staff members (Van der Helm & Stams, 2012). These repressive practices, which can damage client

motivation, include the absence of choice, restrictions to activities that promote openness and creativity, and inappropriate use of power or punishment (de Valk et al., 2016). In contrast, youth placed in residential facilities with group climates that promoted individual autonomy and connectedness have been found to have higher levels of motivation (van der Helm et al., 2018) and improved therapeutic alliances (Binder et al., 2008; Ryan & Deci, 2000; Sweeney et al., 2014). Given risks to feelings of self-determination among youth in these environments, it is particularly important for psychotherapists in these settings to establish agency and independence for their clients to foster self-determination and psychological separateness, which are important for the therapeutic alliance (Gutheil & Brodsky, 2011; Harder, 2018).

"Therapist neutrality" is also threatened by a residential context given that these facilities require a certain degree of social control established by staff members (Zimmerman & Cohler, 2000). In one study, youth and caregivers' treatment engagement, including their therapeutic alliances, were significantly lower among youth in high-intensity treatment facilities as opposed to outpatient settings (Becker et al., 2014). Psychotherapists are trained not to advise clients on what life choices to make (Reamer, 2020; Simon, 1992) or be too "rigid, uncertain, critical, distant, tense, and distracted" (Ackerman & Hilsenroth, 2003), which can happen when taking on care-taking or disciplinary roles with clients. Psychotherapists in youth residential treatment facilities are also around their clients far more than psychotherapists with outpatient clients. This yields opportunity for psychotherapists to have a positive influence on the extra-therapeutic factors that impact their client outcomes, as well as potentially negative ramifications due to limitations with therapist neutrality.

Taken together, the additional caretaking and disciplinary roles adopted by psychotherapists in youth residential environments have the potential to cause alliance ruptures. A rupture is defined as a strain on the relationship between psychotherapist and client that leads to client withdrawal or dissatisfaction with therapy and/or psychotherapist (Safran & Muran, 2000). Some potential precipitants to rupture events include the client or psychotherapists' heightened emotions coming into the session, the sensitivity of the topic for the client or psychotherapist, the training and comfort level of the psychotherapist, unmet client expectations of the relationship and/or session, criticism felt by the client, and client disinterest in trying an intervention suggested by their psychotherapist (Coutinho et al., 2011). However, the focus of the influence of psychotherapists on alliance ruptures within the literature is quite minimal (O'Keeffe et al., 2020). Generally, alliance ruptures stemming from psychotherapists are either relational or skill-based in nature, meaning that the psychotherapists' reactions to the client lacked warmth, empathy, or emotional alignment, or that the chosen intervention or response was not implemented or received well by the client (Ackerman & Hilsenroth, 2003; Colli &

Lingiardi, 2009). Less is known about how psychotherapists may rupture therapeutic alliances in youth residential treatment.

Despite the likelihood that a psychotherapist working in youth residential care may need to appropriately deviate from this standardized code of ethics regarding boundary-setting, there is a gap in evidence-based guidelines on how to handle complex decision-making surrounding boundary-setting in the context of mandated care generally (Smith, 2020), and more specifically within youth residential treatment (Gallant, 2003). One study found that psychotherapists held inconsistent beliefs about necessary boundary limitations (Gallant, 2003), which in part can be explained by the broad definitions of boundary-setting in ethical guidelines for psychotherapists in youth residential treatment (Association for the Development of Children's Residential Facilities, 2001). Despite consistent evidence suggesting the impact of boundary-setting on therapeutic alliances in other settings, therapeutic alliances have also been minimally explored in youth residential treatment contexts.

The psychotherapist–client relationship is one of the strongest predictors of treatment outcomes (Murphy & Hutton, 2018); thus, psychotherapists are crucial for residential treatment. Furthermore, although guidelines on therapeutic alliances exist for residential staff broadly (Roest et al., 2023a), there are guidelines to therapeutic alliances for psychotherapists working within youth residential treatment more specifically. Given the preliminary nature of this topic in the literature, the purpose of this qualitative study was to explore psychotherapists' perspectives on the impact of the residential climate on boundary-setting (e.g., dual relationships, psychological separateness, and therapist neutrality) and therapeutic alliances with youth in residential treatment facilities to understand potential discrepancies in boundary-setting practices given a lack of formalized guidance in this area.

## Methods

### *Study Design*

Ethical approval for this study was obtained by the University of Chicago (12/27/19; IRB19-1893). Eligible participants who had worked or were currently working as a psychotherapist at a youth residential treatment center were English-speaking and had access to a device (phone, computer) to participate in a remote interview; there were no eligibility requirements around demographic characteristics of participants. Participants ($N = 10$) all completed a virtual interview given interviewees' geographic distance and COVID-19 restrictions. Eight were Zoom interviews and two were phone interviews (based on participant preference). Although the remote aspect of these interviews may have affected rapport-building and/or ability to interpret facial/body expressions, this decision was most appropriate for the context to ensure

participant comfort and safety. Interview times ranged from 57 to 92 min ($M$ = 73). Follow-up interviews were not conducted to reduce participant burden.

During the interview, participants read through the consent form and provided verbal consent for both participation in the interview and to be audio recorded. To protect the confidentiality of participants, written consent was not collected, and interviews were conducted in quiet and private locations. Participants were told they could stop the interview at any time, and interview data would be deleted at their request. The semi-structured interview consisted of approximately 10 questions regarding psychotherapists' challenges within their workplace, relationships with their clients, training experiences, job requirements, and views on boundary-setting. The semi-structured interview guide is shown in Appendix. Responses were coded based on their relevancy to the present study's research aims; thus, not all responses to questions in the interview guide are represented in the present study. Upon completion of the interview, participants were given time to ask any questions regarding the goal of the research, overarching research questions, and where the results would be distributed. Interview data generated during the current study are not publicly available due to restrictions in the IRB protocol to protect participant confidentiality.

### *Recruitment*

Participants were recruited from five residential treatment centers across the United States (Ethical approval for this study was obtained by the University of Chicago (12/27/19; IRB19-1893)). Initially, participants were recruited via e-mail at a youth residential center that the primary researcher previously worked at considering the difficulty of obtaining participants within this population (e.g., sensitivity of the work, time constraints of psychotherapists). The primary researchers utilized the network they had established at this facility to assist in identifying potential participants. Psychotherapists were given contact information by members of this network to reach out if they were interested. Approximately 20 other youth residential facilities were directly contacted, which yielded limited response rates. Given the limited response rates to agency e-mail recruitments, the primary researchers ultimately leaned into their network to initiate snowball sampling, in which eligible participants received a link to the research advertisement from a previous participant. Social media was also employed to identify psychotherapists. Lastly, participants were recruited through e-mail listservs (e.g., a way of communicating with a group of people over e-mail) used to connect psychotherapists and social media (e.g., Facebook groups for psychotherapists) in efforts to expand and diversify the sample. In these recruitment e-mails, the current study was described as

"an opportunity to share your workplace experiences that could improve workplace environments in residential care." Despite efforts to reach a broader audience of psychotherapists working in this setting, ultimately 10 participants were screened and participated in the study; limitations to recruitment included barriers to recruiting staff in government funded/social services positions such as additional ethical and methodological considerations regarding privacy and fears of retaliation (Drake, 2014) and challenges with recruitment during the COVID-19 pandemic (Cornejo et al., 2023).

### *Sample*

The final sample included participants across five distinct sites (three state-funded; three privately funded). These five residential treatment centers were the residential centers in which the research participants worked. Six participants worked at a state-funded residential facility and four worked at a privately funded facility. State-funded youth residential treatment facilities are those in which a government grant through the Title IV-E of the Social Security Act funds the treatment services for child welfare-involved youth placed in a residential facility as their out-of-home care placement, whereas privately funded facilities receive income from private insurances of families (Center for Health Care Strategies, 2020). Funding sources for youth residential treatment centers have shown to have an impact on families' experiences with youth residential care (Herbell & Graaf, 2023). All the residential facilities were secure facilities, meaning the youths were all consistently under direct supervision from staff. However, the facilities were not "locked," meaning the youth could go "on run" because the doors were only locked on the outside and not on the inside.

All participants in the sample were either currently or previously in psychotherapy positions at a youth residential treatment facility. The training requirements for each facility ranged. Yet, based on insurance requirements to bill for psychotherapy services in a residential facility (Houston et al., 2010), everyone in the sample had completed or were enrolled in a graduate training program toward clinical licensure (e.g., master's degree in clinical mental health counseling, master's degree in marriage and family therapy, master's degree in social work). The exact licensure of each participant was not recorded given this is potentially identifiable information. Clinical supervision was provided at each site. Two participants were clinical supervisors who had previously been psychotherapists within their respective facilities. One participant currently worked in an outpatient hospital clinic but had previously worked at a privately funded residential facility. Another participant was a family psychotherapist who worked with clients across different facilities and had previously worked full time in a privately funded facility. All other psychotherapists were currently

employed at either a privately funded or state-funded facility. All psychotherapists in the study conducted individual psychotherapy on a weekly basis with youth clients at their respective facilities. Information on the number of individual sessions conducted per week, as well as other types of psychotherapy conducted (e.g., group, family) were not recorded as part of this study. In addition to providing psychotherapy services, some psychotherapists were required to spend time working within the milieu, which is the general program routine and residential space (e.g., supervising youth, assisting with program routine, de-escalating crises) (Lee, 2008). Assistance from psychotherapists within the milieu ranged from playing a supporting role in specific instances to working within staff ratio on the milieu. Eight participants were female and two were male. Most participants were White (90%), except for one female who identified as Black. Specific details on sites and participants are excluded to protect participant confidentiality.

### *Data Analysis*

Qualitative responses were coded in NVivo using deductive analysis, in which the research begins with a conceptual framework that guides the coding process (Pearse, 2019). The present study was guided by ethics and regulations surrounding boundary-setting from the American Counseling Association Code of Ethics (Ponton & Duba, 2009). The American Counseling Association Code of Ethics' predefined boundaries used as codes for this project included: dual relationships, psychological separateness, and therapist neutrality. The researcher first transcribed interviews and then read through them multiple times, while taking notes. Transcriptions were first reviewed without applying pre-defined codes to the data, but rather identifying emerging topics (Pearse, 2019). Transcriptions were then reviewed for a second time to capture sentiments regarding the three types of boundaries. Unlike some deductive coding procedures (Pearse, 2019), a priori hypotheses were not determined due to the exploratory nature of this study; however, participant responses were compared against types of boundary crossings identified by the American Counseling Association, which had predetermined definitions (Ponton & Duba, 2009). Codes were reviewed with an additional researcher prior to refinement and determining that saturation had been reached. The validity of the data was determined by using reflective listening with participants to determine the accuracy of the researcher's interpretations. The researcher also used peer debriefing to review data analysis with another unbiased researcher (a university professor with expertise in qualitative analysis) to confirm the accuracy of methodology and interpretations of findings (Creswell & Miller, 2000). Saturation was reached at eight interviews given repeated emerging categories observed from the data (Hennink & Kaiser, 2022). Pseudonyms were assigned to participants to be used for quote analysis.

## Results

Although all psychotherapists mentioned boundary crossings within their job, not all psychotherapists believed that these negatively impacted their therapeutic alliances with clients. Despite receiving training on appropriate boundaries in general clinical settings, interviewees shared that they were not trained on how to adhere to dual relationships, psychological separateness, and therapist neutrality in a residential context. As a result, psychotherapists defined for themselves which boundaries they felt necessary to implement and which boundary crossings were beneficial to their clients. Additionally, the psychotherapists who worked in state-funded centers mentioned more boundary-setting complications because their organizations often expected psychotherapists to fill more roles that required crossing traditional boundaries. These additional expectations resulted from limited staff, minimal training from other residential staff, and the absence of supportive parental figures in clients' lives. Psychotherapists' responses are outlined below as they relate to dual relationships, psychological separateness, and therapist neutrality.

### *Dual Relationships*

When psychotherapists are spread thinly across different roles, they risk crossing the boundary of dual relationships. All the interviewees ($n = 10$) mentioned some type of dual role they had to take on in addition to their psychotherapy duties. In addition to their work in sessions, psychotherapists often took on roles involving reprimanding and parenting youth, as well as supervising other residential staff working directly with youth in the milieu. Although some psychotherapists did not believe that these dual roles harmed their relationships with their clients, all of them expressed multiple roles that they navigated in their position. In what follows, psychotherapists described the roles they have, how they navigate multiple roles, and their perspectives on how these roles shape their relationship with clients.

Some psychotherapists ($n = 3$), like Kevin, who worked at a state-funded treatment facility, mentioned how the expectation of managing crises in the milieu sometimes interrupted his sessions:

> Sometimes I've had to cancel sessions, right in the middle, and go out and address what's going on in the milieu to keep that safe. It's tough because therapy is all about the process of staying in the moment with the kid, but when you have chairs flying everywhere and kids fighting, you have to pause.

Kevin expressed that this was not an ideal situation for conducting therapy and sustaining motivation for this client, but he felt it was important to prioritize crises for the overall safety of the program. Kevin continued on to acknowledge that the expectation to be available at a moment's notice to

manage crises did present challenges to his sessions, but he did not believe that leaving sessions abruptly damaged his relationships with his clients.

Bill, another psychotherapist at the same state-funded residential facility as Kevin, concurred:

> If you would have asked me a few years ago, I would have said that therapists and clinicians are the last people that should be involved in direct behavior management or specifically in physical holds. My perspective has changed over time since working in a residential setting. I don't think that the therapeutic alliance is harmed by setting limits within the milieu or even participating in a physical hold. The opposite of being a detriment in the therapeutic relationship, it can make it more meaningful in some ways.

The "physical hold" that Bill referred to is a technique for de-escalating youth, which involves placing the youth in a certain restrained position so that they cannot harm others or themselves (Steckley, 2012). Bill acknowledged that, initially, he was hesitant to physically restrain youth but has since found benefits to assuming this responsibility because it can develop the safety felt by clients.

Other psychotherapists ($n = 3$) agreed that being around clients in holds (e.g., verbally deescalating them, observing their behaviors) can help them to feel supported and process the situation. One other psychotherapist, Jennifer, a clinical supervisor and previous psychotherapist at another state-funded residential facility, expressed the potential benefits of being on a physical hold with a client by explaining that psychotherapists can approach these restraints with "a little less reactivity." She cautioned that other direct care staff might be less sensitive with clients compared to psychotherapists due to their heightened exposure to youth violence and other misbehavior.

Another psychotherapist, Sarah, from a privately funded facility, argued that the phrasing of the punishment is crucial to preserving relationships with clients:

> We don't use consequences but there might be things like if the student is bullying another kid or having difficulty with communication, then we might put them on "therapeutic focus" for 24 hours. So, they need to do extra therapy assignments and just spend time reflecting on themselves rather than talking to their peers.

Instead of framing a consequence as a punishment, Sarah explained how psychotherapists should frame punishments as a means of safety. Sarah added that the newer and less trained staff might have less experience doing this. Sarah also pointed out that state-funded facilities are more likely to have less trained staff who are not as equipped at navigating those types of conversations.

Other psychotherapists more definitively said that disciplining youth could be harmful to the therapist–client relationship ($n = 4$). As Angie, a clinical supervisor and former psychotherapist at a state-funded residential facility, said:

> Your role isn't, should not be, "now you're on bronze level hold." Just report back what you observe later because also it creates a crisis. What kid wants to be told that they're not allowed on that rec trip tonight? If the clinician is telling them that, you have a mess to clean up. Don't let us be the bad guy, but you know, let the residential [milieu staff]. Let them so it doesn't kind of interfere with our therapeutic relationship too.

Angie explained that psychotherapists should not take away client privileges. The privileges they refer to come from a commonly adopted behavioral ranking system used in youth residential treatment. In this type of system, "patients begin with a minimum of responsibilities as well as privileges, and through their appropriate behavior on the unit and in their work assignments, patients can gradually 'move up' to step 2 and so on. As they move up, their rights and responsibilities increase" (Bentley, 1987). Thus, this psychotherapist argues that taking away client privileges (such as demoting them to "bronze" level when they are at "platinum" in their privilege ranking system) could cause clients to develop resentment toward them and hurt their therapeutic relationship.

Some psychotherapists mentioned that they had to navigate multiple roles ($n = 6$) with little guidance from their agency about how to appropriately do this in the best interests of their clients. As Megan, a psychotherapist at a state-funded residential facility said:

> I try really hard to keep them [roles] really separate, but [facility name] does not do anything to support that. If it's something you want to do ethically and morally, then it's on you to do it . . . It's really a lot of mental work. It's a lot of taking time to realize the different roles you play and communicating that to your clients.

As Megan shared, she had various roles that she had to fulfill in her position and her organization did not assist her in understanding how to engage in these roles without harming her relationships with clients. She provided the example of physically restraining clients and communicating with her clients about how they would like to process that experience if it ever were to happen. Although Megan worried that physically restraining clients broke important boundaries regarding the therapist-client relationship, she knew that sometimes it was a necessary task for her to do. She decided for herself how to approach these dual roles given physical restraints were a mandatory element of her job, especially when she worked on milieu shifts.

### *Client Separateness*

In the previous section, psychotherapists alluded to complications regarding the development of therapeutic alliances with their clients based on performing different roles within their facility. When asked about their perspectives on navigating various roles within residential care, psychotherapists raised two overarching challenges mentioned: discipline ($n = 10$) and co-

dependence ($n = 5$). In a residential environment, psychotherapists have more time to intervene in their clients' lives and to develop a closeness with clients as compared to outpatient psychotherapy services. Some psychotherapists explained the benefits of forming strong attachments with their clients because they believed this fostered more openness in sessions. Other psychotherapists worried that strong attachments could be harmful if their clients could not independently cope with everyday challenges. Overall, psychotherapists found their clients becoming dependent on their emotional support.

Some psychotherapists ($n = 4$) argued that having more exposure to their clients improved their therapeutic relationship. Deirdre, a family psychotherapist, who previously worked full time at a privately funded facility, attributed this improved therapeutic alliance to the ability to challenge clients more in a residential context:

> I believe we grow the most through our discomfort . . . In individual private practice and the therapeutic alliance, it just takes longer before you can typically challenge clients. But yeah, they [youth in residential facilities] can't leave [laughs]. The good news is if it becomes uncomfortable, they have to stick through it and they learn a lot by having to, to continue to forge ahead. Private practice, you can just bail.

Deirdre discussed the importance of challenging clients in the therapeutic process and the benefits of youths' inability to quit therapy when it becomes challenging in residential care. She argued that residential psychotherapists can take more risks in therapy compared to psychotherapists in private practice, in which clients are easily able to terminate a relationship with their psychotherapist or stop therapy altogether.

Sheila, a psychotherapist at a state-funded facility, agreed that more exposure to clients positively contributed to the therapeutic relationship because psychotherapists know more information about their clients:

> When I compare residential therapy to outpatient, I think that it's very different because you are trying to be more structured. Because the kids do live there, you do get the opportunity to see them daily and kind of have a full scale understanding of what challenges they're facing. So, I think that's a pro in one aspect, but then it also becomes overwhelming in the other aspect, you know, so it's kind of like a two-edge sword.

Others, like Megan, explained that constant time and support provided to clients can jeopardize their sense of autonomy in the relationship:

> I have a client that comes to mind where I was often available to her. I realized over time that she was becoming dependent on me, and I had to pull away. She trusted me, and she was open because I was always there. But a therapist isn't supposed to always be there for you. That's not the dynamic.

Megan worried that psychotherapists might confuse a strong connection with clients with a strong therapeutic alliance, which she saw as distinct. The residential environment complicates the therapeutic alliance because

psychotherapists must decide, without any fixed guidelines, the appropriate amount of time to spend intervening in their clients' lives. Megan continued on to explain that when psychotherapists leave the facility, and their relationships with clients are lost, there are noticeable changes in youth behaviors, implying that these close relationships are not sustainable or equivalent to long-term therapeutic success.

Some psychotherapists claimed that disciplining their clients did not alter their therapeutic relationships and even emphasized the importance of discipline in their treatment ($n = 7$). For example, Georgia, a former psychotherapist at a privately funded facility and a current psychotherapist in an outpatient setting, explained that discipline is "necessary" and "It doesn't matter if I like it or not. I have to do it."

Deirdre agreed and claimed that some psychotherapists "struggle to see how effective it [discipline] can be." She continued:

> I think even the difficult moments and holding hard lines in the sand for kids are effective in the long run because they end up feeling safe, but it's uncomfortable for maybe younger staff who have never had to enforce boundaries.

Jennifer mentioned the influence of discomfort in treatment:

> Trauma-informed is setting limits and boundaries that are clear and consistent because that creates safety. It's not holding their hand and hugging them or feeling bad for them. If a kid isn't completing their treatment work or kind of half-assing it, I'll put them on restrictive status until they finish. I think that's a natural consequence. When a client is not working, I apply a lot of pressure because I want him to feel uncomfortable with not being motivated.

Jennifer mentioned placing clients on "restrictive status" when they do not follow program rules, referring to the removal of certain privileges that a client has on the program, such as going off-campus for activities or visits. She argued that it is important to mimic what natural consequences look like in a treatment setting. To motivate clients, many residential facilities have privilege systems, in which clients receive more luxuries and freedoms for improvements in treatment. Jennifer expressed that consequences help youth learn appropriate behaviors. While traditionally psychotherapists are not trained to discipline their clients, Jennifer explained that the "discomfort" felt by clients when they are disciplined can function as a motivator in a residential setting.

Some psychotherapists ($n = 4$) also suggested that enforcing punishments is crucial for teaching clients skills (e.g., developing positive relationships, de-escalation strategies, grounding techniques). As Stephanie, a psychotherapist at a privately funded facility, argued:

> You're not in the role of a parent, but you have to teach your kids skills. Their actions are harmful to them, others, and their relationships. You have to consequence and provide disciplinary actions out of love.

Stephanie explained that without teaching consequences, psychotherapists fail to show youth how healthy relationships function. Stephanie and some other psychotherapists discussed how youth needs to feel safe and secure, and that disciplining is an important step in providing these things. These psychotherapists argued that clients' basic needs of safety and security need to be met to expect them to engage in more challenging clinical work. Given that forming healthy relationships is important for youth development, Stephanie, like some other psychotherapists, commented that consequences are an important part of the treatment process and developing strong therapeutic alliances.

### *Therapist Neutrality*

If a psychotherapist and client are too emotionally close, a psychotherapist risks crossing the boundary of therapist neutrality (Reamer, 2020; Simon, 1992). It is important to have therapist neutrality so that psychotherapists' biases do not influence clients' decision-making. Therapist neutrality becomes complicated, however, when clients are separated from their families and need substitute or supplemental parenting and emotional support during their time in treatment. When a psychotherapist takes on a parental or familial role in their client's life, they risk forming an emotional bond with this client that is potentially damaging to the therapist–client relationship.

Most psychotherapists ($n = 8$) mentioned that they found themselves in positions where they took on a parental role in a client's life. This seemed to occur more often for psychotherapists within state-funded facilities given that their clients had more absent parental figures. Most psychotherapists who mentioned parenting ($n = 6$) cautioned about slipping into a parenting role but disagreed on where that line should be drawn.

Sheila expressed concerns about taking on a parental role:

> I think it has the potential for the therapeutic alliance to be a little borderline inappropriate just because you see these kids every single day and they put you in this mother figure role . . . some days I just want to be a therapist. You grow attachments as well that maybe you typically wouldn't if you weren't in a residential setting.

Sheila explained that when psychotherapists experience role confusion, this can distract from their therapeutic work with youth and harm their therapeutic alliances. She felt this role confusion when her clients put her "on a platform" and expected more out of the relationship than a typical therapist–client relationship.

Several therapists ($n = 7$) shared that some clients might believe that a residential facility is family-like, but that these views depended on their clients' previous life experiences with family. As Stephanie said:

> Some of our kids who are adopted and who haven't experienced genuine connection, do finally experience genuine connection when they come to our school. Without knowing

> how a family feels, you might perceive any genuine connection to feel like a family. Others might feel less inclined to treat the program like a family because they know who their family is.

Stephanie commented on how clients sometimes want to fill a missing void with staff members by treating them like family members. One of her examples was a client who told her she wanted her to be her mom. She articulated how she was able to normalize for her client the desire of wanting a new mother, while additionally setting a boundary that she cannot fill this role in her life. Megan had similar reservations about providing a false sense of family to the youth in the program.

> To make this false family, to tell these kids that you're family, that they're sisters, but then also when you leave you're gone. Like they are cut out. Real families are not held by ethical codes written by the APA. Real family members can pick you up from the bus station if you don't have a ride. We cannot do that. Their [program] family is not real.

Megan said that creating a narrative of family to youth can be harmful. She rationalized that framing the program as a family can provide a false idea of support or dependency that is not real for the youth. Although traditional families are conceived of as sources of ongoing support or social structure for children, residential facilities cannot function the same. Without being able to provide unconditional support to these youths, Megan questioned whether mirroring the family is beneficial to her clients. Megan, like other residential psychotherapists, needed to set firm boundaries with her clients that she could not function as a parent. Outside of a residential context, there would be fewer scenarios where a psychotherapist would need to navigate this type of conversation.

In contrast, two psychotherapists believed it was important to parent youth in their facilities. As Deirdre explained:

> In an ideal world, in a treatment setting, you're good parents to the kids and you're modeling what that is, that safety and predictability with, you know, with incredible compassion and understanding and a sense of calm through their freakouts without judgment.

Deirdre denoted that psychotherapists act like good parents because they teach appropriate behaviors and role-model, just as a parent would. She continued on to explain, however, that psychotherapists are "less attached to the outcome," meaning that the difference between psychotherapists and parents is that psychotherapists can embody parenting roles, without becoming inappropriately attached to youths' long-term outcomes.

Bill mentioned that he functioned as a parent at times for youth out of what he felt was a necessity:

> They're at this point of desperation and I often find myself kind of functioning as a super parent. There's a little bit of discomfort in that role, but I recognize that it might be what they need right now.

When Bill referred to himself as a "super parent," he meant that he was playing a parenting role for the youth while also providing parenting advice to the youths' actual parents (e.g., foster parents, biological parents, legal guardians). He expressed some discomfort in this role, but he approached it with the understanding that it was a gap that he needed to fill for the best interests of his clients.

## Discussion

From the perspectives of various psychotherapists working within youth residential treatment, it is gleaned that there are discrepancies on how to approach boundary-setting in these contexts and how participating in dual roles in clients' lives influences therapeutic alliances. Given these inconsistencies among psychotherapists' perspectives on appropriate boundaries, it is shown that therapist-client boundaries within residential facilities are not uniformly practiced, which aligns with the limited previous literature on boundary-setting in youth residential treatment facilities (Gallant, 2003). As expected, psychotherapists did reveal challenges to establishing the boundaries that fell under the categories of dual roles, psychological separateness, and therapist neutrality. Psychotherapists did not agree on whether breaches in traditional boundary-setting negatively impacted their relationships with their clients. More specifically, psychotherapists also shared mixed views on the role of "discipline" within treatment. This included but was not limited to managing youth behaviors in the milieu, parenting youth, and holding them accountable for their actions. As well, psychotherapists shared unique factors to state-funded residential care (e.g., clients with different needs, limited staffing/staff training, reduced funding/client resources) that further complicated boundary-setting as compared to privately funded residential facilities. These findings have implications for therapist–client relationships and, subsequently, client outcomes. Given these findings on the inconsistencies in perspectives both within agencies and across diverse agencies, recommendations for best practices in boundary-setting for psychotherapists in these contexts may be warranted to optimize youth outcomes.

In alignment with prior research on the impact of extra-therapeutic factors on client outcomes in youth residential care (Brendtro, 2017; Harder, 2018; Y. Smith & Spitzmueller, 2016), some psychotherapists believed that the residential climate yielded an opportunity for strengthening therapeutic alliances with youth given the exposure to youth outside of the context of therapy sessions. Considering that extra-therapeutic factors are theorized to account for a significant portion of client outcomes (Miller et al., 1997), the therapeutic structure of the milieu for youth (e.g., routine, trauma-informed approach, restorative practices) plays a crucial role in youth treatment. There are models to support best practices for direct care staff working within the milieu, such as

the Child and Residential Experiences (CARE) model, which includes the following six principles: 1) developmentally focused, 2) family involved, 3) relationship-based, 4) competence-centered, 5) trauma-informed, and 6) ecologically oriented (Izzo et al., 2020). Implementation of the CARE model within residential care milieus has shown to improve relationships between direct care staff and clients. However, Izzo and colleagues investigate youth relationships with full-time direct care staff, and not psychotherapists' relationships with youth based on implementation of this model in the milieu. There are currently no established guidelines on the degree to which psychotherapists should intervene with clients in the milieu, as well as any contexts in which they should not intervene due to the risk of harming their alliances with youth. Given that all respondents encountered some type of traditional boundary breech, more research is needed to inform decision-making processes of appropriate psychotherapist boundary-setting in youth residential care.

All psychotherapists in this study shared at one point having to take on multiple roles with a client given institutional expectations, limited resources, or safety concerns. However, psychotherapists shared mixed views regarding the benefits and consequences of engaging in dual roles with clients, such as parenting, mentoring, or disciplining. Some psychotherapists felt that dual roles could complicate their work in therapy by creating inaccurate expectations of the therapist–client relationship. These sentiments align with previous research showing that additional roles can diminish a client's level of trust in their psychotherapist or cause psychotherapists to experience burnout or countertransference, which can both negatively impact the therapeutic alliance (Baca, 2011; Reamer, 2021). Conversely, other psychotherapists in this sample commented on the potential benefits of dual relationships, as mentioned in prior research as well (R. E. Drake et al., 2002). For example, some psychotherapists mentioned that mentoring roles could demonstrate healthy relationships with adults, something often lacking among clients who have experienced adversity (Brady et al., 2017) but have shown to positively impact youth development (Raposa et al., 2019; Van Dam et al., 2018). This impact may be particularly influential from helping professionals (e.g., teachers, doctors, psychotherapists, religious leaders) on academic, physical, and psychosocial youth outcomes based on a meta-analysis (Van Dam et al., 2018).

In contrast, other psychotherapists worried that portraying parental behaviors could mislead clients to form unhealthy attachments or co-dependencies with them that were unsustainable. In standardized therapeutic training, psychotherapists are cautioned against forming inappropriate attachments with clients, given its effect on therapist neutrality (Gutheil & Brodsky, 2011; Simon, 1992). However, due to the caregiving roles of psychotherapists in residential treatment, it is understandable how clients begin to view their psychotherapists as more like family members. One previous study highlights

the benefits of psychotherapists in youth residential care taking on parental attributes given gaps in youth's caretaking (Sng, 2009). In the present study, psychotherapists in state-funded facilities felt more pressured to take on parenting roles because they often worked with clients who had been deprived of parental figures during their upbringing. For clients who will remain under the state's care until they age out of the system (Courtney, 2009), a couple psychotherapists mentioned that cultivating a false sense of family in these clients' lives was misleading and inappropriate for their long-term outcomes when they could no longer have contact with these youths post-discharge (Zirkle et al., 2002). However, according to attachment theory (Bowlby, 2008), considering that staff members at youth residential facilities may take on caregiving roles for youth, these mentoring relationships may be critical for aiding youth in cultivating healthy attachment styles and achieving developmentally appropriate relationships with adults.

In youth residential care settings, it remains unclear which residential staff should be taking on this parental role and the potential damage of psychotherapists intervening as parental figures. Furthermore, while it is known that role confusion can be emotionally harmful to both the psychotherapist and client (Herlihy & Corey, 2014), little is known about role confusion experienced by psychotherapists working within youth residential care. Due to the complexities of caretaking in the context of youth residential facilities, it is critical that psychotherapists process their caretaking roles with specific clients under clinical supervision. Additionally, more training for these psychotherapists on appropriate mentoring approaches within youth residential care could be helpful in guiding psychotherapists.

In this study, psychotherapists also expressed mixed perspectives on the impact of redirecting youth behaviors or providing youth consequences on their therapeutic relationships. In this sample, some psychotherapists thought it was important to engage in rule enforcement with youth to instill cooperation, respect, and most importantly, overall safety on the unit. This finding aligns with previous research indicating that the rules are important for constructing order within residential environments and for youth behavioral modification (Bunner & Yonge, 2006). Previous research also shows that adolescents also perceive some rules and regulations to be appropriate if they believe these rules are fair and meaningful, whereas adolescents feel more repression when they consider rules to be an unjust use of power (de Valk et al., 2019). In this study, psychotherapists shared perspectives on opportunities within youth residential care to blend discipline with trust, respect, and empathy to meet the diverse needs of the youth they serve. This reflects the concept of "procedural justice," a social-justice approach to rehabilitation which emphasizes trust, autonomy, respect, and care and concern (Hough et al., 2010). The tension between care and control, as well as the benefits of implementing procedural justice, have been shown to be effective in

contexts similar to youth residential care such as mandated mental health practice (Weller, 2018) and youth involved in the justice system (Stutts & Cohen, 2022). More research is needed to explore the potential utility of implementing procedural justice frameworks into this specific environment.

Also, regarding milieu behaviors, psychotherapists shared different ideas about who should initiate or participate in physically restraining youth in extreme scenarios. All residential staff must complete "therapeutic crisis intervention" training (Holden & Powers, 1993) to know the correct techniques for placing youth in restraints while reducing their discomfort. Although participants in this sample were adamant that psychotherapists in residential care must learn *how* to properly physically restrain youth in residential care, they were not always taught *when* it is most appropriate for them to be involved in a restraint as opposed to a direct care staffer. In the present study, some interviewees were adamant that psychotherapists should not participate in physical holds due to risks of psychotherapist countertransference and potentially harming the therapeutic alliance (Colli & Ferri, 2015). Other psychotherapists were less certain, speaking on the potential benefits of psychotherapists engaging in holds given their therapeutic training, while also acknowledging their potential harm. It is possible that some psychotherapists endorsed participating in physical holds with clients because they worked in an environment that normalized these boundary crossings out of necessity. In alignment with past research (Steckley, 2012), the current study shows psychotherapists' uncertainties regarding when to aid in physical restraints. Given these uncertainties, it is important that policy is created to determine when participation in physical restraints is warranted for psychotherapists and details what type of role they should play in the physical hold to minimize potential harm for clients. Considering psychotherapists mentioned limited staffing to be a reason for their involvement in past restraints, it may be important to consider increasing the number of staff per youth on shifts to decrease psychotherapists' chances of being in a physical hold with a youth out of necessity.

Contrary to previous literature criticizing the need for physical restraints (Nunno, Holden, & Tollar, 2006; Steckley, 2010), no psychotherapist claimed that physical restraints were completely unnecessary. This may in part reflect the framework of youth residential treatment facilities prioritizing safety (Eltink et al., 2024), and physical restraints being considered an important part of safety. One study among staff members in a youth residential treatment facility found that 78% of staff reported that, in their last restraint with a youth, they were "pretty sure they needed to do the restraint for the safety of others"; yet, approximately a quarter of respondents also worried about the potential safety hazards of the restraint on the youth. There is mixed literature on the necessity of physical restraints in promoting safety in youth residential treatment environments (Roy et al., 2021). Youths in residential treatment have

expressed that physical restraints can negatively impact their relationship with staff and, contrary to intention, result in lowered feelings of safety if done improperly (Steckley & Kendrick, 2008). Additionally, research has also shown the impact of increased trainings, staff qualities, and supervision on reductions in the use of physical restraints in youth residential facilities (Minjarez-Estenson, 2016; Roy et al., 2021; Slaatto et al., 2022), highlighting the possibility of limiting restraints altogether through alternative trauma-informed practices and de-escalation techniques. Furthermore, improved communication among team members in youth residential treatment facilities has been linked to reduced use of restraints and seclusion (Roy et al., 2020), which in turn has implications for better treatment outcomes among youth (Leipoldt et al., 2019). Thus, more attention should be paid to bolstering trainings and fostering healthy staff relationships to improve the residential climate and ideally reduce the need for restraints from all staff members, including psychotherapists.

## Limitations

Study findings should be interpreted with various limitations in mind. Research has shown that interviewees' responses may in part reflect their perceived stakes of the interview (e.g., if the information could be leaked to their employer) (Carr, 2011); thus, responses may be different for participants if they were currently employed at their facility or previously worked at a facility considering potential repercussions from their employer if their responses were to be shared (despite being told their responses would be kept confidential). This risk might feel heightened for those in higher-level positions, such as clinical supervisors, who may have faced more pressure to describe their organization in a positive framework. Their positions and involvement in enforcing agency policies might have deterred them from expressing criticisms of their organizations or led them to justify behaviors of staff that they did not necessarily agree with. The sample could have also potentially been biased given the researchers used their own network for recruitment purposes. Although saturation was reached on major themes, the sample was too limited to draw distinctions between endorsement of salient themes based on characteristics of the participant or the type of residential facility they worked in. This could have been possible with a larger sample size; however, the sample was limited due to the difficulty of conducting research within residential facilities and receiving approval from organizations to interview psychotherapists, as well as the additional strains of conducting research during a global pandemic (COVID-19). With a greater number of residential facilities and psychotherapists, the trends that were emerging, such as differences in privately funded and state-funded facilities, might have been clearer.

## Conclusion

This study aimed to explore boundary-setting and therapeutic alliances in youth residential care. It is clear from this research that psychotherapists are not all working under similar residential guidelines. Psychotherapists are rather motivated by their own agencies' goals, their unique training background, and their own personal and moral justifications for their practices. Without understanding the impacts of boundary-setting and best practices within a residential environment, psychotherapists could unintentionally limit their clients' progress by either refraining from providing appropriate discipline or from overstepping as an authoritative figure. Special attention should be paid to how conditions in state-funded residential facilities can pose an additional threat to boundary crossings due to limited staffing, funding, and clients with diverse developmental and support needs. Coursework on context-specific boundary-setting should be incorporated into training programs for psychotherapists and clinical social workers. Further research is needed to develop measures specifically designed for therapeutic alliances in residential contexts. Additionally, more research from client perspectives is needed to fully understand the impact of discipline on therapeutic relationships in residential environments. Empirical research needs to inform therapist–client relationships as opposed to only traditional boundary-setting guidelines that do not always apply to residential contexts.

## Acknowledgments

This paper and research would not have been possible without the support of my thesis advisor, Dr Eugene Raikhel at the University of Chicago. His mentorship, research expertise, and manuscript edits have helped this study reach its full potential.

## Disclosure Statement

No potential conflict of interest was reported by the author(s).

## Funding

No funding was received to assist with the preparation of this manuscript.

## ORCID

Charis Stanek http://orcid.org/0000-0002-9937-0743

## References


Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review*, *23*(1), 1–33. https://doi.org/10.1016/S0272-7358(02)00146-0

Asnaani, A., & Hofmann, S. G. (2012). Collaboration in multicultural therapy: Establishing a strong therapeutic alliance across cultural lines. *Journal of Clinical Psychology*, *68*(2), 187–197. https://doi.org/10.1002/jclp.21829

Association for the Development of Children's Residential Facilities. (2001). *Code of professional obligation and conduct*.

Baca, M. (2011). Professional boundaries and dual relationships in clinical practice. *The Journal for Nurse Practitioners*, *7*(3), 195–200.

Baier, A. L., Kline, A. C., & Feeny, N. C. (2020). Therapeutic alliance as a mediator of change: A systematic review and evaluation of research. *Clinical Psychology Review*, *82*, 101921. https://doi.org/10.1016/j.cpr.2020.101921

Becker, K. D., Kiser, L. J., Herr, S. R., Stapleton, L. M., Barksdale, C. L., & Buckingham, S. (2014). Changes in treatment engagement of youths and families with complex needs. *Children & Youth Services Review*, *46*, 276–284. https://doi.org/10.1016/j.childyouth.2014.09.005

Bentley, K. J. (1987). Major legal and ethical issues in behavioral treatment: Focus on institutionalized mental patients. *Behavioral Sciences & the Law*, *5*(3), 359–372. https://doi.org/10.1002/bsl.2370050309

Bickle, K. (2021). Staff experiences of stress and coping in a residential treatment facility for youth. *Journal of Child and Youth Care Work*, *27*, https://doi.org/10.5195/jcycw.2021.17

Binder, P.-E., Holgersen, H., & Nielsen H∅stmark, G. (2008). Re-establishing contact: A qualitative exploration of how therapists work with alliance ruptures in adolescent psychotherapy. *Counselling and Psychotherapy Research*, *8*(4), 239–245. https://doi.org/10.1080/14733140802363167

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, *16*(3), 252–260. https://doi.org/10.1037/h0085885

Bowlby, J. (2008). *A secure base: Parent-child attachment and healthy human development*. Basic Books.

Brady, B., Dolan, P., & Canavan, J. (2017). 'He told me to calm down and all that': A qualitative study of forms of social support in youth mentoring relationships. *Child & Family Social Work*, *22*(1), 266–274. https://doi.org/10.1111/cfs.12235

Brendtro, L. (2017). *The other 23 hours: Child care work with emotionally disturbed children in a therapeutic milieu*. Routledge. https://doi.org/10.4324/9781315133706

Bunner, K., & Yonge, O. (2006). Boundaries and adolescents in residential treatment settings: What clinicians need to know. *Journal of Psychosocial Nursing and Mental Health Services*, *44*(9), 38–44. https://doi.org/10.3928/02793695-20060901-06

Byers, A. N., & Lutz, D. J. (2015). Therapeutic alliance with youth in residential care: Challenges and recommendations. *Residential Treatment for Children & Youth*, *32*(1), 1–18. https://doi.org/10.1080/0886571X.2015.1004285

Campos-Ramos, M. A. (2016). *Seasoned licensed clinical therapists' perceptions of boundary setting with mental health clients* [Ph.D]. Capella University. https://www.proquest.com/docview/1818936852/abstract/BD0733155C34403EPQ/1

Carr, E. S. (2011). Qualifying the qualitative social work interview: A linguistic anthropological approach. *Qualitative Social Work*, *10*(1), 123–143. https://doi.org/10.1177/1473325009359389

Center for Health Care Strategies. (2020). *How can Medicaid support the treatment costs for youth in residential programs? Casey Family Programs*. https://www.casey.org/residential-reimbursement/

Coady, N. F. (1993). The worker-client relationship revisited. *Families in Society*, *74*(5), 291–300. https://doi.org/10.1177/104438949307400504

Colli, A., & Ferri, M. (2015). Patient personality and therapist countertransference. *Current Opinion in Psychiatry*, *28*(1), 46–56.

Colli, A., & Lingiardi, V. (2009). The collaborative interactions scale: A new transcript-based method for the assessment of therapeutic alliance ruptures and resolutions in psychotherapy. *Psychotherapy Research*, *19*(6), 718–734. https://doi.org/10.1080/10503300903121098

Cornejo, M., Bustamante, J., Del Río, M., De Toro, X., & Latorre, M. S. (2023). Researching with qualitative methodologies in the time of coronavirus: Clues and challenges. *International Journal of Qualitative Methods*, *22*, 16094069221150110. https://doi.org/10.1177/16094069221150110

Courtney, M. E. (2009). The difficult transition to adulthood for foster youth in the US: Implications for the state as corporate parent. *Social Policy Report*. https://eric.ed.gov/?id=ED509761

Coutinho, J., Ribeiro, E., Hill, C., & Safran, J. (2011). Therapists' and clients' experiences of alliance ruptures: A qualitative study. *Psychotherapy Research*, *21*(5), 525–540. https://doi.org/10.1080/10503307.2011.587469

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into practice*, *39*(3), 124–130.

de Valk, S., Kuiper, C., van der Helm, G. H. P., Maas, A. J. J. A., & Stams, G. J. J. M. (2016). Repression in residential youth care: A scoping review. *Adolescent Research Review*, *1*(3), 195–216. https://doi.org/10.1007/s40894-016-0029-9

de Valk, S., Kuiper, C., van der Helm, G. H. P., Maas, A. J. J. A., & Stams, G. J. J. M. (2019). Repression in residential youth care: A qualitative study examining the experiences of adolescents in open, secure and forensic institutions. *Journal of Adolescent Research*, *34*(6), 757–782. https://doi.org/10.1177/0743558417719188

Drake, G. (2014). The ethical and methodological challenges of social work research with participants who fear retribution: To 'do no harm'. *Qualitative Social Work*, *13*(2), 304–319. https://doi.org/10.1177/1473325012473499

Drake, R. E., Wallach, M. A., Alverson, H. S., & Mueser, K. T. (2002). Psychosocial aspects of substance abuse by clients with severe mental illness. *Journal of Nervous & Mental Disease*, *190*(2), 100. https://doi.org/10.1097/00005053-200202000-00006

Duppong Hurley, K., Lambert, M. C., Gross, T. J., Thompson, R. W., & Farmer, E. M. Z. (2017). The role of therapeutic alliance and fidelity in predicting youth outcomes during therapeutic residential care. *Journal of Emotional and Behavioral Disorders*, *25*(1), 37–45. https://doi.org/10.1177/1063426616686756

Eltink, E. M. A., Roest, J. J., Van der Helm, G. H. P., Heynen, E. J. E., & Kuiper, C. H. Z. (2024). Safety first! Residential group climate and antisocial behavior: A multilevel meta-analysis. *International Journal of Offender Therapy and Comparative Criminology*, 0306624X241252052. https://doi.org/10.1177/0306624X241252052

Elvins, R., & Green, J. (2008). The conceptualization and measurement of therapeutic alliance: An empirical review. *Clinical Psychology Review*, *28*(7), 1167–1187. https://doi.org/10.1016/j.cpr.2008.04.002

Ferreira, S., Magalhães, E., & Prioste, A. (2020). Social support and mental health of young people in residential care: A qualitative study. *Anuario de Psicología Jurídica*, *30*(1), 29–34. https://doi.org/10.5093/apj2019a12

Florsheim, P., Shotorbani, S., Guest-Warnick, G., Barratt, T., & Hwang, W.-C. (2000). Role of the working alliance in the treatment of delinquent boys in community-based programs. *Journal of Clinical Child Psychology*, *29*(1), 94–107. https://doi.org/10.1207/S15374424jccp2901_10

Gallant, L. D. (2003). *Relationship boundaries among residential staff and youth*. Mount Saint Vincent University. https://www.collectionscanada.gc.ca/obj/s4/f2/dsk4/etd/MQ90897.PDF

Gelso, C. J., Kivlighan, D. M., Jr., & Markin, R. D. (2018). The real relationship and its role in psychotherapy outcome: A meta-analysis. *Psychotherapy*, *55*(4), 434.

Gerber, C. (2019). Working with Involuntary Clients-When Control Becomes an Element of Counselling/Die Arbeit mit unfreiwilligen Klientinnen und Klienten Wenn Kontrolle zum Bestandteil von Beratung wird. *Praxis der Kinderpsychologie und Kinderpsychiatrie*, *68*(4), 286–305. https://doi.org/10.13109/prkk.2019.68.4.286

Glass, L. (2003). *The gray areas of boundary crossings and violations*. https://doi.org/10.1176/appi.psychotherapy.2003.57.4.429

Green, J. (2006). Annotation: The therapeutic alliance–a significant but neglected variable in child mental health treatment studies. *Journal of Child Psychology and Psychiatry*, *47*(5), 425–435.

Gutheil, T. G., & Brodsky, A. (2011). *Preventing boundary violations in clinical practice*. Guilford Press.

Gutterswijk, R. V., Kuiper, C. H. Z., Lautan, N., Kunst, E. G., van der Horst, F. C. P., Stams, G. J. J. M., & Prinzie, P. (2020). The outcome of non-residential youth care compared to residential youth care: A multilevel meta-analysis. *Children & Youth Services Review*, *113*, 104950. https://doi.org/10.1016/j.childyouth.2020.104950

Harder, A. T. (2018). Residential care and cure: Achieving enduring behavior change with youth by using a self-determination, common factors and motivational interviewing approach. *Residential Treatment for Children & Youth*, *35*(4), 317–335. https://doi.org/10.1080/0886571X.2018.1460006

Harder, A. T., Knorth, E. J., & Kalverboer, M. E. (2013). A secure base? The adolescent-staff relationship in secure residential youth care. *Child & Family Social Work*, *18*(3), 305–317. https://doi.org/10.1111/j.1365-2206.2012.00846.x

Hennink, M., & Kaiser, B. N. (2022). Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Social Science & Medicine*, *292*, 114523. https://doi.org/10.1016/j.socscimed.2021.114523

Herbell, K., & Graaf, G. (2023). Parents' perspectives in accessing psychiatric residential treatment for children and youth: Differential experiences by funding source. *Children & Youth Services Review*, *154*, 107148. https://doi.org/10.1016/j.childyouth.2023.107148

Herlihy, B., & Corey, G. (2014). *Boundary issues in counseling: Multiple roles and responsibilities*. John Wiley & Sons. https://books.google.com/books?hl=en&lr=&id=FD2tBQAAQBAJ&oi=fnd&pg=PR5&dq=therapist+role+confusion+and+client+outcomes&ots=9UrfkVA3E_&sig=IQ46XEHESvdbG-YHQAgfyZ4bQF0

Herlihy, B., & Corey, G. (2015). *Boundary issues in counseling: Multiple roles and responsibilities* (3rd ed.). American Counseling Association. https://doi.org/10.1002/9781119221586

Holden, M. J., & Powers, J. L. (1993). Therapeutic crisis intervention. *Journal of Emotional and Behavioral Problems*, *2*(1), 49–52.

Hough, M., Jackson, J., Bradford, B., Myhill, A., & Quinton, P. (2010). Procedural justice, trust, and institutional legitimacy. *Policing: A Journal of Policy and Practice*, *4*(3), 203–210. https://doi.org/10.1093/police/paq027

Houston, M., Trivedi, H., Axelson, A., Barron-Seabrook, S., Berland, D., Glasser, M., & Sarvet, B. (2010). *Principles of care for treatment of children and adolescents with mental illnesses in residential treatment centers*. American Academy of Child & Adolescent Psychology.

Izzo, C. V., Smith, E. G., Sellers, D. E., Holden, M. J., & Nunno, M. A. (2020). Improving relationship quality in group care settings: The impact of implementing the CARE model. *Children & Youth Services Review*, *109*, 104623. https://doi.org/10.1016/j.childyouth.2019.104623

Kahan, B. (with Internet Archive). (1994). *Growing up in groups*. H.M.S.O. http://archive.org/details/growingupingroup0000kaha

Kendrick, A. (2013). Relations, relationships and relatedness: Residential child care and the family metaphor. *Child & Family Social Work*, *18*(1), 77–86. https://doi.org/10.1111/cfs.12040

Lee, B. R. (2008). Defining residential treatment. *Journal of Child & Family Studies*, *17*, 689–692.

Leipoldt, J. D., Harder, A. T., Kayed, N. S., Grietens, H., & Rimehaug, T. (2019). Determinants and outcomes of social climate in therapeutic residential youth care: A systematic review. *Children & Youth Services Review*, *99*, 429–440. https://doi.org/10.1016/j.childyouth.2019.02.010

MacCoun, R. J. (2005). Voice, control, and belonging: the double-edged sword of procedural fairness. *Annual Review of Law and Social Science*, *1*(1), 171–201. https://doi.org/10.1146/annurev.lawsocsci.1.041604.115958

Manso, A., Rauktis, M. E., & Boyd, A. S. (2008). Youth expectations about therapeutic alliance in a residential setting. *Residential Treatment for Children & Youth*, *25*(1), 55–72. https://doi.org/10.1080/08865710802209826

Mathews, L. L., & Gerrity, D. A. (2002). Therapists' use of boundaries in sexual abuse groups: An exploratory study. *Journal for Specialists in Group Work*, *27*(1), 78–91. https://doi.org/10.1177/0193392202027001007

Michaud, P.-A., Blum, R. W., Benaroyo, L., Zermatten, J., & Baltag, V. (2015). Assessing an adolescent's capacity for autonomous decision-making in clinical care. *Journal of Adolescent Health*, *57*(4), 361–366. https://doi.org/10.1016/j.jadohealth.2015.06.012

Miller, S. D., Duncan, B. L., & Hubble, M. A. (1997). Escape from babel: Toward a unifying language. *Adolescence*, *32*(125), 247. https://proxy.lib.ohio-state.edu/login?url=https://www.proquest.com/scholarly-journals/escape-babel-toward-unifying-language/docview/1295899612/se-2

Minjarez-Estenson, A. (2016). *Factors influencing the use of physical restraints on children living in residential treatment facilities* [Walden Dissertations and Doctoral Studies]. https://scholarworks.waldenu.edu/dissertations/2163

Morán, J., Díaz, M. F., Martínez, C., Varas, C., & Sepúlveda, R. P. (2019). The subjective experience of psychotherapists during moments of rupture in psychotherapy with adolescents. *Research in Psychotherapy: Psychopathology, Process, and Outcome*, *22*(1), 346. https://doi.org/10.4081/ripppo.2019.346

Murphy, R., & Hutton, P. (2018). Practitioner review: Therapist variability, patient-reported therapeutic alliance, and clinical outcomes in adolescents undergoing mental health treatment - a systematic review and meta-analysis. *Journal of Child Psychology and Psychiatry*, *59*(1), 5–19. https://doi.org/10.1111/jcpp.12767

Nunno, M. A., Holden, M. J., & Tollar, A. (2006). Learning from tragedy: A survey of child and adolescent restraint fatalities. *Child Abuse and Neglect*, *30*(12), 1333–1342.

O'Keeffe, S., Martin, P., & Midgley, N. (2020). When adolescents stop psychological therapy: Rupture-repair in the therapeutic alliance and association with therapy ending. *Psychotherapy*, *57*(4), 471.

Olver, M. E., Stockdale, K. C., & Wormith, J. S. (2011). A meta-analysis of predictors of offender treatment attrition and its relationship to recidivism. *Journal of Consulting & Clinical Psychology*, *79*(1), 6–21. https://doi.org/10.1037/a0022200

Pearse, N. (2019). An illustration of deductive analysis in qualitative research. *18th European Conference on Research Methodology for Business and Management Studies, 264*. https://books.google.com/books?hl=en&lr=&id=Uc-hDwAAQBAJ&oi=fnd&pg=PA264&dq=deductive+coding+process&ots=Mn9rucKwXi&sig=16Rn9n1WhftxWCKjXpvYm8RLIE

Pietz, C. A., & Mattson, C. A. (2014). *Violent offenders: Understanding and assessment*. Oxford University Press.

Ponton, R. F., & Duba, J. D. (2009). The ACA code of ethics: Articulating counseling's professional covenant. *Journal of Counseling & Development*, *87*(1), 117–121. https://doi.org/10.1002/j.1556-6678.2009.tb00557.x

Raposa, E. B., Rhodes, J., Stams, G. J. J. M., Card, N., Burton, S., Schwartz, S., Sykes, L. A. Y., Kanchewa, S., Kupersmidt, J., & Hussain, S. (2019). The effects of youth mentoring programs: A meta-analysis of outcome studies. *Journal of Youth & Adolescence*, *48*(3), 423–443. https://doi.org/10.1007/s10964-019-00982-8

Reamer, F. G. (2020). *Boundary issues and dual relationships in the human services*. Columbia University Press. https://doi.org/10.7312/ream19402

Reamer, F. G. (2021). Boundary issues and dual relationships in the human services.

Roehrle, B., & Strouse, J. (2008). Influence of social support on success of therapeutic interventions: A meta-analytic review. *Psychotherapy Theory, Research, Practice, Training*, *45*(4), 464–476. https://doi.org/10.1037/a0014333

Roest, J. J., de Poll, W.-V., Peer Van, M. J., der Helm, G. H., Stams, G. J. J., & Hoeve, M. (2023a). A three-level meta-analysis on the alliance-outcome association in child and adolescent psychotherapy. *Research on Child and Adolescent Psychopathology*, *51*(3), 275–293. https://doi.org/10.1007/s10802-022-00986-2

Roest, J. J., Van der Helm, G. H. P., & Stams, G. (2022). Alliance ruptures in residential youth care: An ecological systems perspective. *The Therapeutic Alliance in Child and Adolescent Psychotherapy and Residential Youth Care*. https://www.kcsamenredzaam-hsleiden.nl/assets/files/roest-j-j-therapeutic-alliance-in-child-and-adolescent-psychotherapy-and-residential-youth-care.pdf#page=198

Roest, J. J., Van der Helm, G. H. P., & Stams, G. J. J. M. (2016). The relation between therapeutic alliance and treatment motivation in residential youth care: A cross-lagged panel analysis. *Child & Adolescent Social Work Journal*, *33*(5), 455–468. https://doi.org/10.1007/s10560-016-0438-4

Roest, J. J., Welmers Van de Poll, M. J., Van der Helm, G. H. P., Stams, G. J. J. M., & Hoeve, M. (2023b). A meta-analysis on differences and associations between alliance ratings in child and adolescent psychotherapy. *Journal of Clinical Child & Adolescent Psychology*, *52*(1), 55–73. https://doi.org/10.1080/15374416.2022.2093210

Roy, C., Castonguay, A., Fortin, M., Drolet, C., Franche-Choquette, G., Dumais, A., Lafortune, D., Bernard, P., & Geoffrion, S. (2021). The use of restraint and seclusion in residential treatment care for youth: A systematic review of related factors and interventions. *Trauma, Violence & Abuse*, *22*(2), 318–338. https://doi.org/10.1177/1524838019843196

Roy, C., Morizot, J., Lamothe, J., & Geoffrion, S. (2020). The influence of residential workers social climate on the use of restraint and seclusion: A longitudinal study in a residential treatment center for youth. *Children & Youth Services Review*, *114*, 105035. https://doi.org/10.1016/j.childyouth.2020.105035

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *The American Psychologist*, *55*(1), 68–78. https://doi.org/10.1037/0003-066X.55.1.68

Safran, J. D., & Muran, C. J. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. Guilford Press.

Shechory, M., & Sommerfeld, E. (2007). Attachment style, home-leaving age and behavioral problems among residential care children. *Child Psychiatry and Human Development*, *37*(4), 361–373. https://doi.org/10.1007/s10578-007-0051-z

Shirk, S. R., Caporino, N. E., & Karver, M. S. (2010). The alliance in adolescent therapy: Conceptual, operational, and predictive issues. In *Elusive alliance: Treatment engagement strategies with high-risk adolescents* (pp. 59–93). American Psychological Association. https://doi.org/10.1037/12139-002

Simon, R. I. (1992). Treatment boundary violations: Clinical, ethical, and legal considerations. *The Bulletin of the American Academy of Psychiatry and the Law*, *20*(3), 269–288.

Slaatto, A., Mellblom, A. V., Kleppe, L. C., & Baugerud, G. A. (2022). Safety in residential youth facilities: Staff perceptions of safety and experiences of the "basic training program in safety and security". *Residential Treatment for Children & Youth*, *39*(2), 212–237. https://doi.org/10.1080/0886571X.2021.1978035

Smith, M. (2020). Recognising strategy and tactics in constructing and working with involuntary social work clients. *Australian Social Work*, *73*(3), 321–333. https://doi.org/10.1080/0312407X.2020.1717562

Smith, Y., & Spitzmueller, M. C. (2016). Worker perspectives on contemporary milieu therapy: A Cross-site ethnographic study. *Social Work Research*, *40*(2), 105–116. https://doi.org/10.1093/swr/svw003

Sng, R. (2009). Family therapy for kids without families: Working systemically with children and young people in residential care. *Australian and New Zealand Journal of Family Therapy*, *30*(4), 247–259. https://doi.org/10.1375/anft.30.4.247

Sprenkle, D. H., & Blow, A. J. (2004). Common factors and our sacred models. *Journal of Marital & Family Therapy*, *30*(2), 113–129. https://doi.org/10.1111/j.1752-0606.2004.tb01228.x

Steckley, L. (2010). Containment and holding environments: Understanding and reducing physical restraint in residential child care. *Children & Youth Services Review*, *32*(1), 120–128.

Steckley, L. (2012). Touch, physical restraint and therapeutic containment in residential child care. *British Journal of Social Work*, *42*(3), 537–555.

Steckley, L., & Kendrick, A. (2008). Physical restraint in residential childcare: The experiences of young people and residential workers. *Childhood-A Global Journal of Child Research*, *15*(4), 552–569. https://doi.org/10.1177/0907568208097207

Strickler, A., Mihalo, J. R., Bundick, M. J., & Trunzo, A. C. (2016). Relationship between time in residential treatment and youth outcomes: Results from a cross-site 5-year analysis. *Journal of Child & Family Studies*, *25*(6), 1860–1870. https://doi.org/10.1007/s10826-015-0347-8

Stutts, M., & Cohen, J. R. (2022). The role of hopelessness and procedural justice on depressogenic outcomes in serious adolescent offenders. *Law and Human Behavior*, *46*(6), 415.

Sweeney, A., Fahmy, S., Nolan, F., Morant, N., Fox, Z., Lloyd-Evans, B., Osborn, D., Burgess, E., Gilburt, H., McCabe, R., Slade, M., Johnson, S., & McInnis, M. G. (2014). The relationship between therapeutic alliance and service user satisfaction in mental health inpatient wards and crisis house alternatives: A cross-sectional study. *PLOS ONE*, *9*(7), e100153. https://doi.org/10.1371/journal.pone.0100153

Van Dam, L., Smit, D., Wildschut, B., Branje, S. J. T., Rhodes, J. E., Assink, M., & Stams, G. J. J. M. (2018). Does natural mentoring matter? A multilevel meta-analysis on the association between natural mentoring and youth outcomes. *American Journal of Community Psychology*, *62*(1–2), 203–220. https://doi.org/10.1002/ajcp.12248

van der Helm, G. H. P., Kuiper, C. H. Z., & Stams, G. J. J. M. (2018). Group climate and treatment motivation in secure residential and forensic youth care from the perspective of self determination theory. *Children & Youth Services Review*, *93*, 339–344. https://doi.org/10.1016/j.childyouth.2018.07.028

Van der Helm, G. H. P., & Stams, G. J. J. M. (2012). *Conflict and coping by clients and group workers in secure residential facilities*. Progression in forensic psychiatry: About boundaries, 553–564.

Weller, P. (2018). Therapeutic jurisprudence and procedural justice in mental health practice: Responding to 'vulnerability'without coercion. In *Critical Perspectives on Coercive Interventions* (pp. 212–224). Routledge.

Zimmerman, D. P., & Cohler, B. J. (2000). From disciplinary control to Benign Milieu in children's residential treatment. In P. Zimmerman (Eds.), *The forsaken child* (pp. 28–31). Routledge.

Zimmermann, D., Wampold, B. E., Rubel, J. A., Schwartz, B., Poster, K., Schilling, V. N. L. S., Deisenhofer, A.-K., Hehlmann, M. I., Gómez Penedo, J. M., & Lutz, W. (2021). The influence of extra-therapeutic social support on the association between therapeutic bond and treatment outcome. *Psychotherapy Research*, *31*(6), 726–736. https://doi.org/10.1080/10503307.2020.1847344

Zirkle, D. S., Jensen, M. A., Collins-Marotte, J., Murphy, R. J., & Maddux, C. (2002). Therapeutic practices and ethical beliefs of professionals working with adolescents in residential treatment. *Counseling and Values*, *46*(2), 108–117.

Zur, O. (2007). *Boundaries in psychotherapy. Ethical and clinical explorations*. APA. https://psycnet.apa.org/fulltext/2007-00030-000-FRM.pdf

## Appendix

(1) Describe a typical day at your job.
   (a) Routine
   (b) Obligations
   (c) Outlier days
(2) Tell me about the role you play in this facility.
   (a) Expectations of staff
   (b) Expectations of clients
   (c) Expectations of self
(3) Describe the flexibility in your job.
   (a) Sessions
   (b) Scheduling
   (c) General requirements
(4) What is your relationship with your clients like?
   (a) Sessions
   (b) Milieu shifts
(5) Does the program feel like a family to youth at your agency from your perspective?
   (a) Why or Why not?
(6) What aspects of youth residential treatment impact therapeutic alliances with clients?
(7) What challenges do you face in boundary-setting with clients in a youth residential treatment facility, if any at all?
(8) What sort of disciplinary role do you think therapists should have in a youth residential treatment facility, if any at all?
(9) Do therapists at your agency work on the milieu? If so, how do you interact with clients on milieu shifts?
(10) What is your opinion on therapists assisting in physical holds with youth at your agency?