In the House of Change:
The Making and Remaking of Female Youth in Residential Treatment

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ABSTRACT

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This study explores the experiences of female youth in a residential treatment center serving adolescents in the New York juvenile justice, foster care, and special education systems. Findings are based on 11 months of ethnographic fieldwork and semi-structured interviews with eight female juvenile justice residents and ten staff members on the campus. Drawing on a robust literature in psychological anthropology and critically applied medical anthropology, as well as work on pathology and criminality in psychology, sociology, and philosophy, the study uncovers the processes through which a group of adolescent girls are made and remade within the space of residential treatment. I argue that such processes are contingent upon specific arrangements of institutional life that work toward the reform and reconstitution of individual selves.

The chapters in this study demonstrate how institutional arrangements shape the lives of female youth in complex ways that are not entirely consistent. Some of these arrangements are wrought from above through the formal categorization of youth by their referral source, the psychiatric diagnoses attached to their case records, the staffing structure, and the design of therapeutic interventions. Others, however, are tinkered with from below, with residents and staff alike redefining the space of residential treatment and the type of work that gets done on the campus. What emerges is a complex interplay between the fairly strict principles structuring the institution and the creative work by residents and staff encountered in the minutiae of daily life. This interplay works to underscore the idea that categories (of referral sources, of diagnoses, of therapeutic interventions) are in flux, shaping youth and also shaped by youth in turn.

Although this work is primarily ethnographic in nature, it also pays attention to the historical material that is linked to current perceptions about residential treatment, delinquent youth, and psychiatric disorder. I argue that deep understanding of the institutional arrangements at the center of this work depends on knowledge about the past and about transformations in the treatment of youth over time. This historical context is especially important for understanding the enduring ambivalence about residential treatment and for thinking about what place residential treatment centers might occupy on the continuum of treatment options for youth with behavioral and emotional health problems. By situating my findings within the broader context of residential treatment and juvenile justice in the United States, I call attention to some of the policy implications that arise from this study and suggest opportunities for re-envisioning residential treatment in the current child welfare environment.

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This study is the product of years of study and evolving relationships that cut across my professional and personal life. I feel deep gratitude for the many people who have nurtured it from the start and seen it to completion. First and foremost, I wish to thank the residents and staff of "Edgewood" who so graciously allowed me to conduct research on the campus where they live and work. They welcomed me into their daily lives, shared their experiences with me, and tolerated the presence of my little red notebook for many months. I hope the work here speaks to some of their experiences and perhaps also allows them to see facets of Edgewood in new ways.

The National Science Foundation and the Wenner Gren Foundation provided generous financial support for the data collection phase of this study.

I feel lucky to have found individuals across Columbia University who showed interest in my work and were dedicated to mentoring me through the long process of writing a dissertation. At Teachers College, my advisor, Charles Harrington, sparked my interest in psychological anthropology and has provided constant support since my first days as a graduate student. At Columbia's Mailman School of Public Health, Kim Hopper has offered steady counsel in helping me think through my data and the implications of my findings. At Barnard, Lesley Sharp has talked with me at length about my ideas and has pushed me to integrate theory more rigorously—with strong results. Lesley Bartlett at Teachers College and Jennifer Wisdom at the New York State Psychiatric Institute rounded out my dissertation committee. I have been fortunate enough to work with Jennifer on extracurricular research that has allowed me to continue honing my methodological skills. I am grateful to have put together a committee with such a remarkable group of scholars. This work is undoubtedly stronger because of their contributions.

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To My Parents

INTRODUCTION:
CONCEPTUALIZING RESIDENTIAL TREATMENT AND DELINQUENT YOUTH

Residential treatment for adolescents in the United States is suffering from an image problem due in part to a lack of clarification about what defines it. Since the mid–1990s, economic and political pressures have led to increased support for kin-based living arrangements for youth on the grounds that it is both fiscally prudent and morally correct for children to grow up in families and within communities (Courtney and Hughes-Heuring 2009; Task Force 2009). One result of this trend has been to criticize congregate care arrangements across the board, with little reference to the various types of residential treatment that exist today: group homes, campus-based institutions, and locked facilities are often written about interchangeably and with little regard to meaningful differences that exist among them (Butler and McPherson 2007; Whittaker 2000). In turn, although residential treatment remains an integral part of a continuum of services for youth with behavioral and emotional health problems, scant attention has been given to the more substantive questions that residential treatment raises—questions about the conceptualization of and response to bad behavior in young people, the relevance and impact of categorizing youth, the reconstitution of home among a peer group, and the shape and depth of commitment to notions about personal responsibility.

Because residential treatment arrangements serve a variety of youth—from juvenile delinquents, to youth in the foster care system, to those with serious emotional and behavioral difficulties—residential treatment has generated literature from a wide range of sources. The popular press offers frequent and strident critiques of the juvenile justice system, though it rarely acknowledges the range of placements in which youth are mandated to serve time (Kaufman 2008, New York Times 2007; Zumhagen 2011). Public policy and advocacy groups publish

position papers on residential care (American Association of Children's Residential Centers 2009; Child Welfare League of America 2007; White et al. 2009). Academic journals across disciplines cover research on a host of issues related to the youth who are served in residential placements and to the therapeutic modalities being used to treat them. Thus, in spite of significant conceptual confusion surrounding residential treatment, the field as a whole continues to stimulate research and discussion. However much residential treatment is pushed aside by politicians and advocates, the fact that large numbers of youth in the United States cannot live with their families of origin and that community placements can and often do fail continues to make residential treatment relevant.

Through ethnographic inquiry, this study opens up the complex world of one residential treatment center in New York State that I call Edgewood.[1] I approach Edgewood as an anthropologist, interested not only in the individual actors who live and work there, but also in the interrelationship between those actors and the larger social world of Edgewood. My purpose is to uncover how a group of adolescent girls are made and remade within the space of residential treatment through multiple processes. I argue that such processes are contingent upon specific arrangements of institutional life that work toward the reform and reconstitution of individual selves. In so doing, I aim to provoke questions about the contradictions that arise when institutional power at various levels and under multiple constraints comes up against the youth who are under its charge.

This study is an ethnography first and foremost. Ethnographies accomplish their work through detailed description, using long-term participation in and observation of a place of study to render a faithful—if always incomplete—portrait of life as witnessed. In this particular case,

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1. Edgewood is a pseudonym, as are the names of all places and people in this dissertation with the exception of public places and figures.

findings are drawn from 11 months of fieldwork at Edgewood, a private, non-profit institution

serving approximately 165 youth from four referral sources in New York State: the New York

State Office of Children and Family Services (OCFS; youth in the juvenile justice system); the

New York City Administration for Children's Services (ACS; youth in New York City's foster

care system); local Committees on Special Education (CSE; youth in need of special education

services); and the local Department of Social Services in the county where Edgewood is located

(DSS; youth in the local county's foster care system).

Although this work looks across multiple spaces at Edgewood and covers a range of

issues, two points are worth noting from the outset. First, I spent most of my time in the field

with residents and staff from two female cottages, which I will call Hamilton Cottage and Thayer

Cottage. The data gathered about everyday life at Edgewood are thus informed primarily by

interactions with and reflections from individuals associated with these cottages. This is an

important point to raise because, as I will show, cottages are run by different staff and develop a

distinct feel over time. Second, although the original questions driving my research were focused

on the female juvenile justice population, this work pays attention to female residents from all

four referral sources mentioned above. It is impossible to focus on one group when Edgewood

residents from all referral sources live in cottages together and conduct all aspects of their

campus lives in concert. Furthermore, to do so would have risked adding to the confusion about

residential treatment today. The reality is that residential treatment centers in New York often

serve a diverse set of youth in the same space and with the same approach. As will become clear

throughout this study, the worlds of juvenile justice and foster care are intertwined and

discussion of one group necessarily entails discussion of the other. Indeed, all youth who end up

at Edgewood do so because they have been deemed delinquent, troubled or unmanageable.

The focus on girls in this study is intentional. Adolescent females are a minority at Edgewood (35 percent) as well as in the juvenile justice system in New York State (15.74 percent of admissions to custody in 2009; NYSOCFS 2011) and nationally (14 percent of juvenile offenders in residential placement in 2007; USOJJDP 2011). At the same time, females account for a rising proportion of juvenile delinquency arrests in the United States (Puzzanchera 2009:8) and several large-scale studies have demonstrated that juvenile justice-involved females are at higher risk for mental health disorders than males (Shufelt and Cocozza 2001, Teplin et al. 2002, Timmons-Mitchell et al. 1997, Wasserman et al. 2005). Even so, little research has been dedicated to exploring the experiences of female youth in residential treatment, whose experiences may be unique. This work addresses the gap in the existing knowledge base by looking exclusively at girls.

Although this work is primarily ethnographic in nature, it pays particular attention to the historical material that is linked to current perceptions about residential treatment, delinquent youth, and psychiatric disorder. I argue that deep understanding of the institutional arrangements at the center of this work depends on knowledge about the past and about transformations in the treatment of youth over time. Like Lorna Rhodes' compelling work, *Total Confinement*, my goal is not so much to give a comprehensive historical account—a task too ambitious for this study— but to provide a sense of "temporal depth and resonance of certain practices" (2004:15). Echoes and reverberations of the past are present at Edgewood and the questions that inform this study are anchored in enduring questions about how we respond to individuals who do not conform— especially when they are minorities and from the lowest socioeconomic brackets of society.

As the chapters in this study demonstrate, the institutional arrangements at Edgewood shape the lives of youth in complex ways that are not entirely consistent. Some of these

arrangements are wrought from above through the formal categorization of youth by their referral source, the diagnostic assessments attached to their case records, the staffing structure, and the design of therapeutic interventions. Others, however, are tinkered with from below, with residents and staff alike redefining the space of residential treatment and the type of work that gets done within Edgewood. My purpose in showing these inconsistencies and contradictions is to uncover those moments when taken-for-granted institutional arrangements collide with the perceptions and intentions of residents and to understand the consequences of such friction.

Although this study critiques certain practices at Edgewood, it also insists that places like Edgewood must be protected as part of a continuum of treatment options for youth today. Unlike those who claim youth are always best served in family and community settings, I think residential treatment offers an important and necessary alternative, especially in light of how often—and awfully—some families and communities have failed their youth. My focus on contradictions within the world of Edgewood is thus driven by a spirit of anthropological inquiry that seeks to translate and reframe everyday practices on the campus. My ultimate goal is to uncover the institutional logic of these practices and to explore how staff and residents make meaning of them in turn.

THEORETICAL FRAMEWORK

Thinking about how female residents at Edgewood are made and remade within the space of residential treatment raises a number of provoking questions. What is the purpose of residential treatment and how do different actors in the same environment understand that purpose? How do we make sense of the multiple ways female youth in residential treatment have been categorized and what impact do such categorizations have on one's sense of self? Is there a clear boundary between "normal" and "pathological" functioning? How do female youth

experience clinical interventions—from participating in group therapy to taking psychotropic medications? And what aspirations are expressed when we insist that troubled youth with various mental health problems are still responsible for their behaviors?

Answering these questions requires weaving together diverse theoretical orientations. This study takes an interdisciplinary approach, drawing first on a robust literature in psychological anthropology and critically applied medical anthropology, and integrated in turn with work on pathology and criminality in psychology, sociology, and philosophy. Having been trained primarily in psychological anthropology, I am interested in the interrelationships between the individual and the society in which she is embedded and, more particularly, in the ways mental illness takes on local meanings that are negotiated and renegotiated in time and space. There is ample ethnographic evidence suggesting that mental illness is conceived differently across the globe (Biehl 2005; Kleinman 1988; Kleinman and Good 1985; Luhrmann 2000; O'Nell 1996). Less work has been done on mental illness among youth, however, or on categories of illness that the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) suggests are usually first diagnosed in childhood or adolescence (Carpenter-Strong 2009a, 2009b, Fabrega and Miller 1995, Gremillion 2003, and Harrington 1970 are notable exceptions within anthropology). One of my goals in this study, then, is to demonstrate how longstanding theoretical positions in anthropology and related fields come to bear in the newer terrain of "adolescent psychopathology."

Critically Applied Medical Anthropology

Insofar as this study seeks to uncover certain inconsistencies in the conceptualization and treatment of female youth in residential care, I rely heavily on critically applied medical anthropology. Critically applied medically anthropology is concerned with the role of medical

sciences in producing new forms of knowledge about individuals and their bodies and seeks to understand health issues in light of larger political and economic forces (Baer 1982; Baer et al. 2002; Lock and Scheper-Hughes 1996; Singer 1986, 1989). Nancy Scheper-Hughes (1990) has been influential in shaping my work. Two decades ago, Scheper-Hughes distinguished *critically* applied medical anthropology from *clinically* applied medical anthropology, which, she argued, had failed "to grapple head on with the rather basic incongruity between the interpretive ethnomedical and the positivist biomedical scientific paradigms" (1990:191). Questioning the materialist premises of biomedicine, she went on to call for the critically applied medical anthropologist to take on the role of court jester or "'oppositional' intellectual": "the jester, the oppositional intellectual, works at the margins and sometimes (but not necessarily) from the outside, pulling at loose threads, deconstructing key concepts, looking at the world from a topsy-turvey position in order to reveal the contradictions, inconsistencies, and breaks in the fabric of the moral order without necessarily offering to 'resolve' them" (1990:191). To this end, the critically applied medical anthropology that I draw on in this study—particularly work by Lorna Rhodes (1991, 2004) and Helen Gremillion (2003)—is attuned to the power dynamics that infuse medical encounters and institutions and draws from Foucault's (1988a, 1990, 1995) studies of how the fields of medicine, psychiatry, and criminal justice contribute to knowledge production.

Lorna Rhodes and Helen Gremillion have both taken up the task of grappling with contradictions in settings that are not entirely dissimilar to Edgewood: an emergency psychiatric unit (Rhodes 1991), a maximum security prison (Rhodes 2004), and a psychiatric inpatient unit for the treatment of anorexia among adolescent girls (Gremillion 2003). In all three of these works, attention is drawn to the larger social context in which individual subjectivities are formed—a context that includes the power differentials between the patient/prisoner and

caretakers, the isolation of the patient/prisoner from the rest of society, and assumptions about rational choice and individual responsibility. But emphasis is also placed on daily instances of resistance to show how the totalizing discourses of psychiatry can be disrupted. Gremillion, for example, argues that the pressure to consume a specified number of calories each day on the unit she studied had the unintended effect of leading patients to spend time calculating and recalculating calories and, therefore, to delay eating; thus, the patient "appropriates a mode of surveillance in the hospital—the requirement for precise calorie counting, with results that go on record—to 'anorexic' ends" (2003:17). Throughout this study, I demonstrate the ways in which subjectivities at Edgewood are formed in situ, and often in reaction to the environment of residential treatment. So, too, do I uncover moments of resistance that disrupt the treatment process on the campus. In particular, I suggest that there are multiple contradictions at work in the process of categorizing and diagnosing female youth at Edgewood and that these practices often have unintended effects.

The research of both Rhodes and Gremillion is also instructive insofar as it points us to the competing philosophies and constraints under which staff must operate in institutions like Edgewood. On one level, as Rhodes (2004) shows us when describing the treatment/custody divide that separates mental health workers from prison workers, staff at different levels and from different disciplines may have discordant perspectives on how to interpret and respond to the behavior of individuals. On another level, there may be a larger disconnect between what staff are asked to do (at both a state level and an institutional level) and what can be reasonably accomplished.[2] Rhodes suggests that staff respond to these institutional "binds" with pragmatic and strategic actions, some of which entail a certain amount of resistance through humor and the

2. See also Lipsky (1980) for a discussion of how public-service workers become "street-level bureaucrats" who mediate the relationship between the individual and the state.

subversion of discipline (1991:5-7). Inevitably, "binds" also exist at Edgewood, forcing staff to conceive of new ways to understand their work and render it meaningful.

Problematizing Psychiatry

To employ critically applied medical anthropology in a study of a residential treatment center for youth also entails problematizing American psychiatry in the 21st century. Nearly all residents at Edgewood have been diagnosed with at least one psychiatric disorder prior to being admitted to the campus. This may not be surprising considering residential treatment is on the high end of the continuum of treatment options for youth with behavioral and emotional problems. But what are we to make of the fact that many of these girls have been diagnosed with disorders that did not appear at all in the *DSM* until the 1980s or were rarely diagnosed in youth before the mid–1990s? Have qualitatively new kinds of youth emerged? Or have we simply shifted the boundary between the "normal" and the "pathological"?

Much has been written about the changes made to the *DSM* over time, from its first edition (*DSM-I* 1952) to its most recent edition (*DSM-IV-TR* 2000) (Gaines 1992; Kirk and Kutchins 1992; Kutchins and Kirk 1997; Luhrmann 2000; Shorter 1997). In particular, the literature highlights the paradigm shift represented by the 1980 publication of the *DSM-III*, a text seen as moving psychiatry toward the exclusive use of biomedical models in an effort to enhance its status as a "real science." Below, I utilize the work of Luhrmann (2000) to describe this conceptual shift before moving on to demonstrate how the shift has influenced child and adolescent psychiatric diagnoses and with what consequences.

Tanya Luhrmann's (2000) ethnography of psychiatrists-in-training, *Of Two Minds*, provides compelling evidence that there has been a paradigmatic shift in the way that American psychiatrists are taught to "see" mental illness. On the one hand, there is "psychodynamic"

psychiatry—a style of thinking in which "mental illness is in your mind and in your emotional reactions to other people. It is your 'you.'" On the other hand, there is "biomedical" psychiatry—"an approach to mental illness that treats it as an illness of the body that is more or less comparable to other physical illnesses" (Luhrmann 2000:6). Luhrmann admits the dichotomy is too simplistic, since the field of psychiatry is complex and includes doctors with multiple—often overlapping—orientations. Nonetheless, she provides strong evidence that psychotherapy is being pushed out of psychiatry, making more and more room for a strictly biomedical model of mental illness. She describes, for example, how new psychiatrists are taught to admit patients and present them to their supervisors in ways that encourage them to see psychiatric illness as an organic disease:

> The cumulative effect of the learning process is to imply that for each diagnosis there is an underlying disease, a 'stuff' the diagnosis names, and that the stuff trumps diagnosis. That is, through the process of memorizing the criteria and learning to prototype the categories, psychiatrists learn to talk and act as if the disorders are there in the world, that they are instantly recognizable, and that the printed diagnostic criteria may only partially describe the real disorders. Young psychiatrists behave as if these categories are 'natural kinds.' [Luhrmann 2000:44]

The idea that psychiatric diagnoses are "natural kinds"—that they are neither cultural artifacts nor social conventions but real and discrete diseases—has real consequences; it both narrows our understanding of the experience of mental illness and risks making diagnosis inescapable. To begin, biomedicine's focus on intrapsychic phenomena leaves little room for understanding the social context and contours of mental illness. Whereas Parsons (1958) suggested that mental illness should be defined with reference to the social performance of the individual (and their incapacity to fulfill expectations of social roles), proponents of biomedical psychiatry look at symptoms without regard to the environment in which they occur. Defining someone as mentally ill within the artificial confines of a hospital, or in the case of this study, a

juvenile detention facility or residential treatment center, tells us very little about how that individual functions within the community. More appropriate, as argued by Harrington (1970), would be to classify behavior on the basis of socially relevant categories. This would allow for an understanding of behavior that might convey how symptoms that appear troublesome to society may be adaptive for individuals. So too might it help us reconceptualize appropriate treatment as that which helps individuals to return to social roles within their own communities.

A more serious consequence of seeing mental illness as an organic disease is that it risks eliding class, race and ethnicity with specific diagnoses, which then become inescapable for certain populations. For example, although research examining racial and ethnic differences in the prevalence of psychopathology in adolescents is limited and results are inconsistent (McLaughlin et al. 2007), retrospective chart reviews have shown significant biases in the types of diagnoses that adolescents receive; African American and Hispanic youth were significantly more likely than Caucasian youth to be diagnosed with behavioral problems, whereas Caucasian youth were significantly more likely to be diagnosed with depressive disorders (Delbello 2001; Muroff 2008). Considering that elevated rates of psychiatric disorder have been found in studies of youth in residential treatment (Connor et al. 2008; Drais-Parrillo 2005), as well as in studies of youth in child welfare systems including foster care (McMillen et al. 2005) and juvenile justice (Teplin et al. 2002), and that the youth in these systems are disproportionately minorities from the lowest socioeconomic brackets of society, it is not difficult to see how quickly psychiatric disorder might come to be seen as a natural attribute of these populations.[3]

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3. Two examples illustrate the disproportionate representation of minorities in child welfare systems: (1) African American and Hispanic youth make up 44 percent of New York State's youth population but accounted for 85 percent of admissions to the state's juvenile justice system in 2007 (Task Force 2009); and (2) African American and Hispanic youth make up 35 percent of the population under 19 in the United States but account for 50 percent of youth in foster care (Johnson and Lichter 2010:1; US Dept. of Health and Human Services 2011).

Examining changes to the *DSM* over time as they relate to children and adolescents provides a starting point for thinking about how connections between diagnosis, race, ethnicity, and class become possible. It is especially interesting to trace the place of children and adolescents in the *DSM* because of the overwhelming expansion of child and adolescent-specific disorders in such a short period of time. There is some debate over when children became an object of psychiatric study (see Harwood 2006:37-39 for a discussion of the different perspectives) but it is clear that it was not until the late 19th century that psychiatrists considered the possibility of distinct childhood mental disorders (Silk et al. 2000:714).[4] More important, though, is the far more recent proliferation of diagnoses that can be applied to children emerging since the mid–20th century. Successive editions of the *DSM* demonstrate a significant—and discontinuous—transformation in the conception of child and adolescent psychiatric disorders. In the first edition of the *DSM* (1952), the only diagnoses referencing children or adolescents specifically were "Schizophrenic reaction, childhood type" and three disorders listed under a broad category of "Transient situational personality disturbances": "Adjustment reaction of infancy," "Adjustment reaction of childhood" and "Adjustment reaction of adolescence." Importantly, these later three diagnoses were thought to be "transient"—"acute symptom responses to a situation without apparent underlying personality disturbance"—and thus bounded by stages of maturation (APA 1952:40).

By the time the second edition was published in 1968, a new section of "Behavior disorders of childhood and adolescence" had been added to the disorders included in the *DSM-I*. This section included categories such as "runaway reaction of childhood (or adolescence)" and

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4. Part of the reason for this is the relatively recent invention of childhood and adolescence as distinct life stages. Aries' (1962) classic work suggests that childhood was not considered a unique phase of life until the 17th century; until this time, children were seen as miniature adults. "Adolescence" is an even more recent concept. Psychologist Stanley Hall's work (1904) is considered to be one of the first to conceive of adolescence as a unique developmental category.

"group delinquent reaction of childhood (or adolescence)"—disorders thought to be "more stable, internalized, and resistant to treatment than *Transient situational disturbances* but less so than *Psychoses, Neuroses,* and *Personality* disorders" (APA 1968:50). Thus, as Silk et al. highlight, the *DSM-II* began a trend of "acknowledging the intermediate nature of childhood illness that is less fixed than an adult disturbance but also deserves recognition beyond that of an adjustment reaction or brief transitional change" (2000:719).

If the *DSM-I* and *DSM-II* had only limited reference to children and adolescents, the publication of the *DSM-III* in 1980 led to an acute proliferation in the number of childhood mental disorders. The *DSM-III* accounted for the largest increase in diagnostic categories across all *DSM*s (Kirk and Kutchins 1992:101) and children were not overlooked; the *DSM-III* contained four times as many classifications for children and adolescents as had the *DSM-II* (Silk et al. 2000:721). These classifications were now listed under the heading of "Disorders Usually First Evident in Infancy, Childhood or Adolescence" and included five major categories of disturbance: (1) Intellectual, (2) Behavioral, (3) Emotional, (4) Physical, and (5) Developmental (APA 1980:35-36). In subsequent editions of the *DSM*—the *DSM-III-R* (1987), *DSM-IV* (1994) and *DSM-IV-TR* (2000)—childhood and adolescent disorders have been refined further and age-related qualifiers have been added to many of the existing adult disorders so that they can be diagnosed in children and adolescents as well.

<u>Expanding the Possibilities of Disorder</u>

Two trends are especially important to note in the expansion of the *DSM* over time. The first regards the expansion of behaviors and symptoms included within the psychiatric realm; the second regards the re-labeling of symptoms as other types of psychiatric disorder. In reference to the first trend, it is essential to emphasize that it was only with the publication of the *DSM-III* in

1980 that many of the diagnoses so prevalent today came into existence. Take, for example,

Conduct Disorder, which did not exist as "Conduct Disorder" until 1980, and by 2010 was the

most prevalent psychiatric diagnosis among female youth at Edgewood (43 percent of all female

youth who lived at Edgewood between January and October 2010 were diagnosed with Conduct

Disorder) and the second most common psychiatric diagnosis among adolescent girls (Delligatti

et al. 2003:183; see Appendix A for the diagnostic criteria for Conduct Disorder as they appear

in the *DSM-IV-TR*).[5] In a span of only 30 years then, behaviors once considered "reactions of

childhood or adolescence" have been codified into a discrete disorder that is now one of the most

widely applied diagnostic labels in youth.[6]

One way to understand this move to medicalize an increasing number of adolescent

behaviors is to examine how the diagnostic categories codified in the *DSM-III* emerged around

the same time as other policies directed at criminalizing and controlling youth were being

implemented in the United States. As I will detail in chapter 1, the rise in national crime rates

during the 1960s and 1970s led to the introduction of increasingly harsh criminal legislation

governing youth in the late 1970s and 1980s (measures that have largely been maintained over

time) (Fagan 2010). These legislative changes took place at the same time that the Reagan

administration was inciting new levels of moral panic about racially charged issues by declaring

a "war on drugs" and "getting tough" on "street crime" (Beckett 1994; Hawdon 2001). They also

presaged a more global trend in the rise of neo-liberalism, particularly since the 1980s—a

phenomenon which has resulted in what Wacquant calls "the return of an old-style punitive

5. There is a significant body of literature on Conduct Disorder but prevalence estimates vary among studies. Loeber et al.'s literature review cites prevalence data from a number of population-based studies, showing ranges of approximately 2-16 percent among boys and 1-9 percent among girls (2000:1474). Despite the higher frequency of Conduct Disorder among boys, Conduct Disorder in girls is still common and there is some research suggesting that its prevalence in girls is underestimated due to inappropriate diagnostic criteria, biased perceptions, and social constraints on gender (Delligatti et al. 2003, Keenan et al. 1999).

6. I will return to a discussion about the discursive construction of Conduct Disorder later in this chapter.

state" where law and order are the means for managing poverty (2001:401). John Muncie details what neo-liberal forms of governance have meant for young people: an "adulteration" of youth justice, zero tolerance policing policies, and a powerful discourse on "risk factors" that "perpetuate[s] a series of all-too-familiar moral judgments on the propensity of the poor to commit crime" (2007: 23). While a full exploration of these trends is beyond the scope of this study, it is important to acknowledge them to the extent that they can help explain the broader context in which new types of psychiatric disorder have emerged that pathologize behavior specifically and carry strong undertones of race and class. In this light, "Disruptive Behavior Disorders" such as Conduct Disorder and Oppositional Defiant Disorder were created, at least in part, as a reaction to wider societal trends instigating fear about unruly youth.

Relatedly, the inclusion of new categories of disorder in the *DSM* like Conduct Disorder further complicates the already troubled relationship between psychiatry and the law. The antipsychiatry movement of the 1960s, spearheaded by works from Ronald Laing (1960) and Thomas Szasz (1961), argued that psychiatric diagnoses are stigmatizing labels applied to individuals whose behavior deviates from conventional expectations. Questioning the assumption that people who break the law are "sick" or "unstable," these critics suggested that much of what is called "mental illness" is shaped by societal reactions to behavior rather than anything internal to the individual.[7] Critics of Conduct Disorder have continued this line of questioning more recently by noting the significant disconnect between the definition of mental disorder in the *DSM* and the diagnostic criteria for Conduct Disorder (Harwood 2006; Mallet 2006; Laurence and McCallum 2003; Richters and Ciccheti 1993; Silk et al. 2000; Wakefield

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7. Staub's (2011) recent work, *Madness is Civilization*, resituates the antipsychiatry movement in the politics of the postwar era in the United States. He argues that accounts of mental illness during this time served as an occasion for addressing broader economic, political and social concerns.

1997). Although the *DSM* indicates "deviant behavior" is not by itself a mental disorder and the "the Conduct Disorder diagnosis should be applied only when the behavior in question is symptomatic of an underlying dysfunction within the individual and not simply a reaction to the immediate social context," these perspectives are not incorporated into specific diagnostic criteria (APA 2000). Indeed, as I will demonstrate, Conduct Disorder is a diagnosis given to female youth frequently and, more often than not, on the basis of "deviant behavior" alone. Thus, a young person who breaks the law may easily find herself caught up in two systems—one legal, the other psychiatric—that have become increasingly intertwined.

Re-labeling Disorders

Alongside the growing number of behaviors that now fall under the mantle of childhood and adolescent psychiatric disorders, there has been a meaningful shift in the extent to which disorders once thought of as "adult" disorders are now being diagnosed in children and adolescents.[8] Bipolar Disorder is especially telling in this regard. The *DSM-IV-TR* diagnostic criteria for mania were developed for adult patients with Bipolar Disorder and without regard for the developmental differences between adults and children or adolescents (Kowatch 2009b:7). Nevertheless, the lifetime prevalence of Bipolar Disorder in adolescents is now estimated to be between 1.0 percent and 1.4 percent—higher than the 1.1 percent rate of Bipolar I Disorder found among adults (Kowatch 2009a:2).[9] An examination of the increase in rates of Bipolar

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8. From the perspective of epidemiology, Angold and Costello (2009) argue that the application of "adult-style" diagnostic criteria has been successful in demonstrating that many adult disorders also occur in childhood, and may start even earlier than once thought possible. Without disputing this argument, my focus here is on the discursive practices that make these disorders possible among young people.

9. The *DSM-IV-TR* distinguishes four categories of Bipolar Disorder: Bipolar I Disorder (presence of one or more manic or mixed episodes; depressive episodes may occur); Bipolar II Disorder (presence of one or more major depressive episodes and at least one hypomanic episode but no history of manic or mixed episodes); Cyclothymic Disorder (numerous hypomanic episodes and numerous periods with depressive symptoms that do not meet criteria for a major depressive episode); and Bipolar Disorder Not Otherwise Specified (disorders with bipolar features that

Disorder among children and adolescents is even more illuminating. Using data from the National Hospital Discharge Survey, Blader and Carlson (2007:110) show that the number of children (ages 5-13 inclusive) and adolescents (ages 14-18 inclusive) discharged from hospitals with a primary diagnosis of Bipolar Disorder increased 438.6 percent and 296.4 percent respectively between 1996–2004 (in comparison to an increase of only 56 percent among adults). In 2004, children diagnosed with Bipolar Disorder constituted over one-third of all psychiatrically related discharges; adolescents comprised nearly one-half (Blader and Carlson 2007:109). Notably, rates of Bipolar Disorder among black children and adolescents were lower than rates for other race groups in early survey years but showed a more pronounced rise in later survey years and came to exceed the rates of other groups (Blader and Carlson 2007:112).

The marked increase in the number of children and adolescents receiving a diagnosis of Bipolar Disorder is a source of active controversy and debate that is beyond the scope of this study (see, for example, AACAP 2007, Blader and Carlson 2007, Healy and Le Noury 2007, Moreno et al. 2007, Olfman 2007). But the idea that symptoms previously diagnosed with other disorders are now being re-labeled as Bipolar Disorder is an important one. There are many potential explanations for such re-labeling—not excluding the pharmaceutical marketing of Bipolar Disorder in adults (Healy and Le Noury 2007) or the "upcoding" of behavioral disturbances in order to overcome higher hurdles for obtaining payment from managed care organizations (Blader and Carlson 2007:112). For the purposes of this work, however, I am concerned primarily with the fact of re-labeling itself and with the consequences it has for how youth at Edgewood think about mental illness.

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do not meet the criteria for any specific Bipolar Disorder). However, the literature on Pediatric Bipolar Disorder does not always specify which type of Bipolar Disorder is being considered. The American Association of Child and Adolescent Psychiatry suggests that most studies of juveniles look at Bipolar I Disorder (AACAP 2007:107).

Together, literature on the expansion and re-labeling of psychiatric disorders among children and adolescents provides a framework for understanding the broader sociocultural environment in which Edgewood residents have been diagnosed with a variety of mental health problems. These data give us little in the way of understanding the subjective experiences of youth who have been diagnosed with these disorders, however, and do not reveal how youth make sense of treatment—medication-based or otherwise. To this end, this study derives inspiration from researchers like Carpenter-Song (2009a, 2009b), Floersch (2003), and Floersch et al. (2009) who have worked to fill this substantive gap by conducting qualitative studies with young people about their own subjective experiences with mental illness and psychotropic treatment. It also approaches issues of diagnosis and labeling with more philosophical orientations that consider how ways of categorizing become tied up with an individual's sense of self. I turn to such orientations now with the help of philosopher Ian Hacking.

"Kinds of People"

The work of Ian Hacking offers an especially provocative way of thinking about how the categorization of youth by referral source and the assignment of psychiatric disorder come to bear on residents at Edgewood. Hacking's (1995, 2001, 2002, 2004, 2007) work shows sustained preoccupation with how classifications of people come into being and affect the people classified, as well as with how the effects on the people in turn change the classifications themselves. Two key ideas are carried throughout his line of work that require review here: "making up people" and the "looping effect."

Hacking's first concept—"making up people"—is concerned with "the ways in which a new scientific classification may bring into being a new kind of person, conceived of and experienced as a way to be a person" (2007:285). Hacking has explored this notion with

examples ranging from the emergence of multiple personality disorder (1995) to the

contemporary idea of child abuse (1991) but the most appropriate example for this study is his

discussion of the "criminal" as a specific kind of person that emerges in the 19th century (2001).

The early 19th century marks the point when the social sciences began counting criminal acts and

suicides and, as such, "criminals" and "suicides" emerged as "kinds of people—not just any kind

but kinds about which the new social sciences tried to discover laws as invariable as those in

physics" (Hacking 2001:143).[10] For Hacking, the central point is to demonstrate that while crime

certainly existed well before the 19th century, it was only at this time that a certain discourse

emerged about the criminal as "criminal." Hacking restates his point with a more recent example

of the "serial killer," which he argues only emerged as a label for people around 1970: "I am not

saying that there were no serial killers before 1970, only that this classification, this kind as kind,

emerged about that time" (2001:157).

The parallels between Hacking's discussion of the "criminal" and the emergence of

"Conduct Disorder" are clear, since it is only with the publication of the *DSM-III* in 1980 that

"the adolescent with Conduct Disorder" (and the "criminal child" who requires "reform")

becomes a possibility. Certainly, the types of behavior falling under the label "Conduct

Disorder" have long been sources of public concern. It is only recently, however, that "Conduct

Disorder" has emerged as a way to describe these same behaviors and with it, the assumption

that youth who display them suffer from a mental disorder. The same argument might be made

for other "Disruptive Behavior Disorders" that entered the *DSM* lexicon in 1980 and, to some

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10. Hacking refers to "kinds of people" as "human kinds" throughout much of his work, the intention being to
reference the philosophical concept of "natural kinds"—an idea that certain things group together in nature in a way
that does not depend on humans (chemical elements often are used as the paradigm). In a more recent essay,
however, Hacking writes that he has "jettisoned" the term "human kinds" because of the "simple deduction" that
"there is no such thing as a natural kind" (2007:291,291n). In keeping with Hacking's more recent convention, I will
not refer to "human kinds" in this study.

extent, for a diagnosis like Bipolar Disorder, which, as we have seen, was almost unknown in

child and adolescent populations until the mid–1990s but is now one of the most common

diagnoses among that population. In each of these cases, behaviors that were once described as

"transient" or age-related "reactions" have been discursively displaced by discrete categories of

psychiatric disorder and, in so doing, the youth to which these behaviors are attached have come

to be seen as qualitatively new kinds of people. Hacking's concept of "making up people" is thus

best understood in this case as one involving *remaking* as well as making; "deviant behavior"

exhibited by young people has been re-crafted as a particular type of mental disorder and, in turn,

new kinds of young people have emerged.

These classifications do not exist in a vacuum, however. Insofar as we think of "kinds of

people" as objects of scientific classification, Hacking reminds us that his nominalism is a

dynamic one; categories of people and the people within them come into being "hand in hand

with our invention of the ways to name them" (2002:113). Thus, we arrive at the second key idea

put forth by Hacking—that of the "looping effect." Hacking describes what he means by

"looping":

> It is composed of two basic stages. (a) There is an effect on people who are classified.
> There is a classification K of people, which is made as part of our scientific knowledge.
> Associated with K are what are conjectured to be laws or regularities about people who
> are K. At least some people thus classified change their behaviour in consequence of
> being so classified. (b) It may be necessary to change the criteria or the knowledge about
> people who are K, because in virtue of classification, they no longer fit the old criteria.
> Or at any rate, one may have to modify the regularities about such people, not because
> one was wrong in the first place, but because the people have changed somewhat. This, in
> turn, may affect the people classified, and looping may continue.[11] [Hacking 2004:297]

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11. Hacking counts Erving Goffman as an important influence but he is careful to point out that his conception of
"looping" is different than the "looping effect" described by Goffman (1961) in *Asylums*. From Hacking's
perspective, Goffman's looping is "not so much a case of making a person, as of unmaking a person": "the inmate
reacts to humiliation by a word, a gesture or an action, or just by sulking. This annoys the warden, who makes some
new, humiliating imposition. The inmate reacts. The insult rebounds. The warden tries to punish this further instance
of bad behaviour. And so on" (Hacking 2004:298-299). Thus, whereas Goffman's looping occurs in face-to-face
interaction, Hacking's looping applies to classification itself. The distinction is important given that Hacking has
been criticized for "reinventing the loop," so to speak (see Lynch 2001).

Taken into the realm of criminal behavior, Hacking imagines a scenario for what might happen to a young man who is told that he is genetically disposed to crime. First, the crime prone youth is established as a kind. Then knowledge about the kind—in this case, that the youth is genetically predisposed to violence—is circulated. In turn, the young man learns about his supposed genetic tendency to crime and his urge to commit crime is positively reinforced. This then impacts the knowledge we have about the kind again such that the correlation between crime and genetic markers becomes over-confirmed; experts discover that these individuals are even more dangerous than previously thought (Hacking 2001:157, 2007:298).

Bringing Hacking's work on looping to bear on my own study, I argue that looping effects are present in the case of multiple classifications at Edgewood, "Conduct Disorder" being only one of several. Indeed, because youth at Edgewood are multiply categorized prior to and during their tenure on the campus, there are various instances to watching looping in action; in chapter 2, I demonstrate how female youth interact with "ACS" and "OCFS" categories and in chapter 5, I ask what happens when one resident takes on the label of Bipolar Disorder despite not having been diagnosed as such. In each of these instances, the possibilities for personhood are remade and key questions must be asked. As Hacking writes, "Does one feel different, has one a different experience of oneself, if one is led to see oneself as a certain type of person? Does the availability of classification, a label, a word or phrase, open certain possibilities, or perhaps close off others?" (2004:285). These are questions at the heart of my study and ones I will return to throughout this work.

Individual Choice and Responsibility

The final line of thinking traced within this study involves questions about individual choice and responsibility. In Hacking's work on "making up people" and the "looping effect," he

explicitly favors an existentialist vision of the human condition over an essentialist one. He writes:

> We push our lives through a thicket in which the stern trunks of determinism are entangled in the twisting vines of chance. Still, you can choose what you do, under the circumstances. The choices that you make, situated in the thicket, are what formed you and continue to form you. Responsibility is in part responsibility for that being that you become, as a consequence of choosing. [Hacking 2004:282]

The commitment Hacking makes to an autonomous human being is clear here. But if his commitment is a theoretical one, similar commitments to a rational, self-regulating individual are made in a variety of observable situations.

To begin, it is helpful to note that neo-liberal forms of governance, in addition to ushering in excessively punitive strategies, perhaps ironically have also placed more emphasis on individual responsibility and accountability. David Garland has characterized this trend as being the result of a "responsibilization strategy" whereby central governments seek "to act upon crime not in a direct fashion through state agencies (police, courts, prisons, social work, etc.) but instead by acting indirectly, seeking to activate action on the part of non-state agencies and organizations" (1996:452). The central concern of such a strategy is to devolve responsibility for crime prevention down to communities and individuals. When it works, Garland writes, "the responsibilization strategy leaves the centralized state machine more powerful than before, with an extended capacity for action and influence," while at the same time "erod[ing] the notion of the state as the public's representative and primary protector" (1996:454). Thus, the state both insists responsibility for protection and reform lies with the individual and justifies the retrenchment of welfare measures on the grounds they sponsor dependence (with particularly harsh consequences for the poor).[12]

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12. The contradictions entailed in "responsibilization strategies" resonate with Foucault's (1988b) work on the interaction between "technologies of domination" and "technologies of the self." Foucault suggests that

The move toward strategies of "responsibilization" on a global scale can be seen more concretely in ethnographic work examining how the tendency to privilege notions of autonomy and agency unfolds at the ground level. Returning to Rhodes' (2004) work in a maximum security prison, for example, we see comparable assumptions being made about prisoners. Rhodes describes how prison workers signal their belief that the prisoner alone is responsible for his situation with remarking, "you did the crime, you do the time," (Rhodes 2004:66). She argues the very logic of imprisonment depends on adopting such an attitude: "for the prison to do its work of control, a self capable of responding to and eventually internalizing that control must be assumed for the prisoner" (Rhodes 2004:67). In fact, Rhodes suggests contemporary corrections "considers the attribution of responsibility a prerequisite for full humanity"—the idea being that to see the prisoner as a moral agent is to show him respect (2004:83).

Rebecca Lester (2009) presents similar ideas in her work on the configuration of authenticity in a private eating disorder treatment center. There, Lester describes how the managed care approach to care depends on the assumption of an autonomous individual with the capacity to reason. In such a model, autonomy entails only "procedural authenticity"—"*capacities to act* in accordance with the values and ideals one endorses"—rather than any sort of "epistemic authenticity," which "has to do with the degree to which one's internal 'radio' is 'tuned' to those values" (Lester 2009:288). Lester writes about this approach to care: "grounded in a rational choice model of human behavior, the managed care approach assumes that patients will make good faith use of treatments as prescribed in order to maximize health and minimize

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"technologies of power, which determine the conduct of individuals and submit them to certain ends or domination, an objectivizing of the subject," are in "constant interaction" with "technologies of the self, which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being" (1988b:18). It is in the contact between these two technologies that Foucault arrives at his concept of "governmentality." Many writers have used governmentality as a lens through which to understand neo-liberalism (see, for example, Burchell et al. 1991, Barry et al. 1996; Rose 1999).

harm" (2009:289). As in Rhodes' work then, Lester demonstrates that even in environments where individual selves may be compromised (whether by physical or mental illness or incarceration), the people watching over individuals continue to insist on their capacity to be responsible for their choices.

Rhodes (2004) and Lester (2009) do not end their analysis there, however. Rather, each shows the extensive slippage involved in assumptions about individual choice and responsibility in these environments. To begin, such assumptions contain multiple contradictions. Rhodes suggests there is a fundamental contradiction in "allow[ing] the 'social man' to wither on the other side of the bars while, at the same time, attributing to him an almost superhuman ability to exercise his will" (2004:60). Furthermore, Rhodes adds, assuming that a prisoner is responsible for his own choices inside the prison excludes the very real possibility that many of the choices individuals make in prison are wrapped up in the conditions in which they are held.

For Lester, contradictions arise when a managed care model comes up against the clinic's psychodynamic perspective, which recognizes that mental illness often includes maladaptive actions and self-destructive intentions, the causes of which may be outside conscious awareness (2009:289). Clinicians end up caught between two modes of action, forced to discharge patients who are seen as "better" in the eyes of managed care (i.e., patients who have made "positive health outcomes" such as weight gain) even when they believe continued treatment is necessary. In such cases, Lester observes a curious phenomenon: the emergence of what she calls "borderline talk" (2009:285). Lester suggests that in cases where clinicians are conflicted about what constitutes ethical treatment, they may end up appropriating the very language of the

managed care organizations they oppose; reframing clients as "borderline" makes it acceptable—even ethical—to discharge them from treatment.[13]

Assumptions made about a rational and self-regulating individual also raise important questions about the relationship between will and obedience. Rhodes questions "whether what one is *made* to do can—or should—become what one *chooses* to do" (2004:63). That is, can changes that are forced upon individuals—prisoners in Rhodes' case and eating disordered patients in Lester's—ever be internalized? Or is change something performed in these environments (perhaps because it is forced)? Rhodes suggests that inside the prison, inmates are assumed to be liars, manipulators and con artists; their actions inside the prison are performance and strategy (2004:169). Lester, meanwhile, gives us the example of Courtney, a 14-year-old girl with anorexia who was forced into treatment for an eating disorder by her parents and who, upon initial resistance to eating and attending therapeutic groups, was told that if she did not comply with the program she would be sent to a medical facility for re-feeding and then returned to the clinic. Lester writes, "Courtney capitulated—sort of. She accepted the feeding tube without protest. She began to eat her meals and snacks. She attended all therapeutic groups as well as individual therapy. She followed all the rules. And she talked constantly about how as soon as she met her weight goal and was discharged, she would go right back to her eating disorder" (2009:290). Even as Courtney improved from a procedural standpoint in the eyes of managed care, then, staff felt that her "pseudo-compliance" said much about the severity of her illness and the need for continued treatment (Lester 2009:290). Taken to its limits, talk of inmates who

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13. Ware et al. (2000) documented a similar phenomenon in their study of a community mental health clinic. There, despite the fact that the transition to managed care involved meaningful changes to clinical practice and was accompanied by outright resistance, clinicians engaged the language of managed care as a way to ensure that treatment plans would be approved or extensions of service authorized. Ware et al. suggest that learning the language of managed care may ultimately mean being "*made over* as a professional." "The more clinicians engage the new discourse, the more accustomed they become to thinking in terms of the categories and relationships the language of managed care provides. They absorb it; it becomes inscribed as part of their identity as mental health professionals. In the process, that identity is remade" (2000:19).

"know the game" (Rhodes 2004:167) or eating disordered patients who demonstrate "pseudo-compliance" (Lester 2009:290) can, as Rhodes writes, "destabilize the very idea of a real or truthful self" (2004:171). This may be particularly ironic in places that insist on the idea of rational and responsible human beings but both Rhodes and Lester give examples of individuals who are pushed out of the realm of treatment because they do not show sufficient investment in their own rehabilitation.

It is important to acknowledge that Edgewood is neither Rhodes' prison (the maximum security, "control unit" of a state correctional facility) nor Lester's clinic (a private eating disorder treatment center). Assumptions about—and possibilities for—individual action and authenticity will thus be configured quite differently at Edgewood. On the one hand, it is clear Edgewood residents are not prisoners in a maximum–security unit. By living in a therapeutic environment, Edgewood residents have far more opportunities for generating feelings of self-worth and agency than those presented to prisoners. On the other hand, it is also clear Edgewood residents may not be afforded the same level of care that is possible in private clinics because Edgewood's resources are necessarily limited. However much critical self-reflection and "owning" one's actions are the indicators of "successful treatment" in the treatment center Lester describes, these goals may not be realistic in a place that is strapped for resources in both time and personnel (Lester 2009:290).

Despite these differences, the themes Rhodes and Lester touch upon remain vital to this study because they occupy a central place at Edgewood. As I will demonstrate in subsequent chapters, much emphasis is placed on the individual choices residents make during their stay on the campus and how they are responsible for their experiences at Edgewood, for their rehabilitation, and for their eventual discharge. Of course, there is recognition of and

appreciation for the myriad forces that have impacted residents' lives, many of which are beyond individual control: abusive or substance-abusing parents, inadequate housing, failing schools—the list goes on. But in spite of—or perhaps because of—the weight of these external forces, focus remains centered on how youth at Edgewood are masters of their own fate. Whether the freedom to choose is a realistic possibility for this set of youth or an expression of our highest aspirations is something I consider throughout this study.

METHODOLOGY

Methods of Study

As an ethnography written within the tradition of anthropology, this manuscript relies on a particular set of methods honed by anthropologists since the early 20th century. Following Hopper (2003), I conceive of ethnography as both "framework" and "fieldwork." On the one hand, as a "framework" for knowledge, ethnography must attend to location in its broadest sense; here it requires documenting some of the history of juvenile justice and residential treatment in New York and tracking recent changes in juvenile justice policy, as well as understanding revisions in the *Diagnostic and Statistical Manual of Mental Disorders* across its multiple editions. Furthermore, "framework" refers to the theoretical paradigms that inform the researcher's thinking at every stage, shaping research questions and facilitating the transformation of raw data to field notes and, ultimately, to finished text. On the other hand, as "fieldwork," ethnography is marked by active involvement in a particular place for a sustained period of time. Anthropological training instills an ethos of fieldwork whose claim to valid and reliable data is substantiated by the time ethnographers spend in the field; anthropologists know because they were there. The goal of fieldwork, then, is to generate data that will aid the

ethnographer in rendering a faithful—if incomplete—portrait of everyday life as his or her study

participants see it.

From January through November 2010, I spent four to five days each week on the

Edgewood campus, attending a variety of staff and resident meetings in the mornings and

splitting my afternoons between two female cottages, Hamilton Cottage and Thayer Cottage.

Morning meetings consisted of biweekly "Rounds" on residents,[14] Strategic Case Reviews,[15] and

Family Team Conferences.[16] Afternoons were spent participating in the daily life of the

cottage—facilitating after-school and clinical activities, providing assistance with homework,

attending cottage events, and helping staff members supervise residents. My involvement in

formal activities was supplemented by engaging more informally with residents and their

families. Throughout the duration of my fieldwork, I attended three Family Day events where

residents' family members were invited to a campus party. I also accompanied residents and staff

on off-campus recreational trips, seeing a concert and a show in Manhattan, going clothes

shopping for a school graduation, and attending a two-day sleepover camp with three cottages.

In addition to the time I spent on the Edgewood campus, I conducted fieldwork off-

campus in two primary settings. First, I accompanied campus staff on "home assessments" that

are required before any resident is permitted to go on a weekend home visit. Participating in

these home assessments took me to multiple neighborhoods throughout New York City and

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14. Similar to the way medical doctors make daily rounds on patients, "Rounds" at Edgewood are meetings where staff from a variety of disciplines come together to discuss all residents in a cottage. "Rounds" will be described in more depth in Chapter 3.

15. Strategic Case Reviews involve staff across disciplines meeting to discuss one resident for 1–2 hours. The stated purpose of the meeting is "to improve the results of efforts to improve [Resident's Name] safety, stability, and permanency." In all Strategic Case Reviews I attended, the residents discussed were individuals who presented particularly complicated issues—for example, a pattern of violent behavior, a history of multiple hospitalizations, or an inability to find a permanent placement to which the resident could be discharged.

16. Family Team Conferences are required and bring together residents and their guardians on the campus for a meeting. The meetings are supposed to provide an update for all parties on how the resident is doing and what the goals for the family are moving forward.

allowed me to visualize the settings where residents live when they are "on the outside." Home assessments were also instrumental to my work because they provided me with a way to obtain parental consent for the semi-structured, recorded interviews I conducted with female youth. Second, I went to Family Court in two boroughs on several occasions to meet potential residents prior to their sentencing and to attend scheduled court dates with residents already living at Edgewood.

In order to triangulate data from a variety of sources, I complemented participant observation with periods of systematic observation throughout the year and with 18 semi-structured interviews completed between July and November 2010. Systematic observation is a valuable research technique for focusing on specific behaviors or patterns that emerge during the course of everyday life in the field. It was particularly useful during the Guided Group Interactions that residents participated in each week; since I was not an active participant in this group, I was able to take a more macro-level view of the residents.

I conducted and tape-recorded semi-structured interviews with eight juvenile justice residents (all female; ages 15–17) and ten staff (nine female and one male). Semi-structured interviews allowed for a flexible interview format where I was able to probe multiple areas related to juvenile justice, residential treatment, and perceptions of mental health. Staff provided informed consent to be interviewed. For interviews with residents, residents provided assent and their legal guardians provided consent (since residents were under the age of 18). The Teachers College Institutional Review Board provided oversight for human subjects protection and approved all study procedures. Given the sensitive nature of this research, I also obtained a Certificate of Confidentiality from the National Institute of Health. As with most ethnographies, names, dates and places have been changed to protect the identity of those involved except in the

case of public officials and institutions. However, all people represented are individuals; no composite characters have been created.

The final technique I used in this research was to gather case record information on each of the female residents that I interviewed. Having gained permission to review these records at the same time as obtaining consent for interviews, I was able to read through the existing documentation for each resident I interviewed. Written records, of course, are replete with flaws, not the least of which is that they give us an unanchored view of an individual. As Silverstein and Urban remind us, "to turn something into text is to seem to give it a decontextualized structure and meaning, that is, a form and meaning that are imaginable apart from the spatiotemporal and other frames in which they can be said to occur" (1996:1). It is useful to point out that my choice to utilize case records was informed by a desire to look at multiple iterations of the same individual—on paper, in conversations about, and through personal interaction.

Data Analysis

All data collected during this study were analyzed using Atlas.ti 6 software, which aids in coding, organizing, and retrieving qualitative data (Muhr 2004). Codes were developed in two phases—first in open coding to capture all themes and ideas and then in more focused coding. During the process of coding data, I also wrote memos on certain topics to get a clearer sense of themes I wanted to pursue. Such practices draw heavily on grounded theory (Glaser and Strauss 1967, Strauss and Corbin 1998), which focuses on generating theory from systematic examination of and frequent comparisons across data. Grounded theory relies on an inductive approach and suggests that field notes should be analyzed by minimizing analytical or theoretical commitments. Following Emerson et al. (1995:144), however, I believe that "analysis is at once inductive and deductive," since "analysis pervades all phases of the research enterprise" and it is

impossible to assume that researchers write their notes in the field and read them after without any guiding theoretical concerns. As described earlier in this chapter, my analysis was guided by diverse theoretical orientations ranging from psychological anthropology and critically applied medical anthropology, to work on pathology and criminality in psychology, sociology and philosophy.

Methodological Challenges

As with any research project, challenges arise and methods that first appear promising prove stickier than anticipated. In my case, challenges arose in the scope of this project and the utility of interview methods. First, while this project initially proposed to interview the parents or legal guardians of residents in addition to female residents and staff, it was difficult to find parents/guardians and none of the parents/guardians I did speak to agreed to participate in their own interview. Part of this was a logistical problem since parents/guardians do not visit the campus regularly and proved hard to track down at their own homes. Even so, parents and guardians did not express interest in being interviewed about their daughter's juvenile justice history and mental health. While willing to talk freely with me about this history in the company of the Edgewood staff member conducting the home assessment, several parents and grandparents told me that their daughter or granddaughter was the person with whom I needed to talk, minimizing the value of their own perspective. I also suspect, however, that many of these parents and guardians have grown weary of talking about their backgrounds and their child's delinquency involvement. Most of them have a history of involvement in child welfare services and juvenile justice—among other public agencies—and this implies an unending schedule of appointments with social workers, lawyers, and community-based workers. Understandably, agreeing to give an additional hour of time on this topic may seem overly burdensome.

The second methodological challenge presented in the field was related to the use of semi-structured interviews that were more formal than my regular interactions with staff and youth on campus. Interviews are inevitably artificial encounters and they evoke power differentials between the interviewer and the interviewee (Briggs 1986). Having spent months developing relationships with my research participants, the transition from a casual relationship to a more formal one proved somewhat awkward. Some staff members were nervous about telling me things that may have reflected poorly on the agency (despite repeated assurances of confidentiality) while others articulated feeling they were being tested on their job qualifications.

The youth I interviewed showed little or no concern about confidentiality but presented other challenges. One girl was AWOL[17] for several weeks before the end of my fieldwork, thus making it impossible for the interview to take place; another was discharged before I was able to schedule the interview. Other residents had to be encouraged to elaborate beyond monosyllabic responses, some with more success than others. The challenges of interviewing teenagers have been documented (see, for example, Bassett et al. 2008) and should not be underestimated. Still, interviews remained a useful way to elicit additional data and to give participants the chance to communicate their own experiences and perspectives. This was particularly important in allowing residents to detail their time in the juvenile justice system—a process that often uncovered omissions and false information in their case records.

The difficulties I encountered fitting into the role of interviewer speak to the larger challenges that face any researcher entering the field. Anthropologists are notoriously self-conscious about their position as a researcher and have long wrestled with maintaining the fragile balance between professional stranger and friend (Agar 1980; Malinowski 1984; Powdermaker

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17. AWOL—Absent Without Leave—is the term used by staff and residents at Edgewood when a resident has left the campus without permission.

1966). In my own case, I had to remind people often about my role as a researcher and not as an employee of Edgewood (in particular, I was mistaken for a cottage staff member or a social work intern). At the same time, I had to align myself carefully with administration members, cottage staff, and residents. This involved a certain balancing act on my part, since doing research alongside cottage staff often meant listening to complaints about the administration and since fostering relationships with residents often required discretion and non-disclosure when talking with staff members.

Finally, I have reflected often on the implications of being an affluent, white, female who is documenting lives that are so very different from her own. Such differences must be taken seriously because they undoubtedly influenced my research—both in terms of how I understood the social world of Edgewood and how people related to me. I do think the willingness of staff and residents to tell me certain facts—about drug use or other illicit activities for example— reflects a certain level of hard-earned trust. But, as Mitchell Duneier reminds readers at the outset of his book on sidewalk vendors, it is best to remain "humble" about the rapport we achieve as researchers "because one never really knows" (1999:4). Indeed, in instances where I found out that residents had been untruthful about something they told me, I was reminded of the delicacy of my relationships. There is no simple way to overcome these travails of fieldwork. But I make a deliberate effort throughout this study to document and vet the source material on which I rely.

A Note on Labels and Names

A final methodological note is important regarding the manner in which I refer to Edgewood residents and staff in these pages. First, the reader will notice that I refer to residents

frequently as "ACS residents, "OCFS residents," "CSE Residents," or "DSS residents."[18] This is

not merely for convenience. Rather, residents are spoken about with and speak to each other

using these acronyms on a daily basis. When a new resident arrives at Edgewood, for example, it

is not long before her cottage mates will ask her, "You ACS or OCFS?" Similarly, residents will

refer to themselves with the abbreviations, indicating, "I'm ACS" or "I'm OCFS." The fact that

these labels are taken up freely and frequently is but one indicator of how meaningful they are on

the campus (and how common and ramifying the looping effect). Indeed, as I will show, these

acronyms signify multiple things at once to those familiar with the social world of Edgewood.

Second, I refer to many staff in this study with the title, "Ms." I do this not to indicate

their gender—although most of my interactions were with female staff—but because this is how

female staff are addressed by residents and how I addressed them during my fieldwork.

Residents and staff likewise called me "Ms. Leah" even though I never introduced myself this

way and told people frequently that they could call me just by my first name. The title is a sign

of respect and also reinforces the distance between residents and staff. Even though I have been

out of the field for almost a year at the time of writing this, I still refer to the staff with the title

"Ms." when I return for visits and I am still called "Ms. Leah."

ORGANIZATION OF THE STUDY

This study is organized into five chapters, each of which is framed by a central issue

related to how female youth are made and remade within the space of residential treatment.

Chapter 1 situates Edgewood in time and space, tracing its origins to the orphan asylums of the

early 19th century and contextualizing its history within the larger move to institutionalize

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18. ACS residents (youth referred by the New York City foster care system); OCFS residents (youth referred by the New York State juvenile justice system); CSE (youth referred by Committees on Special Education); DSS (youth in the county foster care system).

troubled youth and remove them from mainstream society. The relevant historical material

suggests both long-standing ambivalence about how to deal with youth who cross a threshold of

socially acceptable behavior as well as a troubled relationship between treatment and

punishment. This chapter also orients the reader to more current debates about residential

treatment and, in particular, to the active changes that the juvenile justice system in New York

State is undergoing at the time of writing. Such information attests to the still unresolved

questions about how to deal with a segment of the population that has such high needs and also

provides context for understanding some of the political and financial constraints under which

Edgewood must operate.

Chapter 2 uncovers the world of Edgewood by looking at the residents who live there and

at the physical space of the campus and its daily routines. I detail the different referral pathways

residents can take to the campus in order to argue that the classification of female youth by

referral source has important implications for institutional functioning as well as for how female

youth are perceived by staff and peers and perceive themselves in turn. I then examine the

Edgewood environment and the rhythms of daily life on the campus. I suggest the Edgewood

campus is uncomfortably positioned between an institutional world that demands consistent

schedules and rules and an outside world that constantly threatens to disrupt that consistency.

This positioning has meaningful consequences for how female residents understand the

environment in which they live and for how both female residents and staff members

conceptualize the purpose of Edgewood and the locus of responsibility for change.

Chapter 3 turns to attention to the staff world at Edgewood and to how working

relationships play out in an environment that presents an impossible bind: to treat residents

adequately and return them to their home communities quickly. I argue that working

relationships are reflective of a staffing structure that divides employees along the lines of custody and treatment functions and that this division impacts perceptions of Edgewood and beliefs about how residents should be treated. I also examine how staff overcome sources of discord to get work done and maintain solidarity in a difficult working environment. I place particular emphasis on the role of humor in staff meetings and the way in which humor serves to bolster morale in a difficult working environment.

Chapters 4 and 5 pursue themes of making and remaking by analyzing how they appear within the primary clinical intervention at Edgewood, Guided Group Interaction. In chapter 4, I examine how peer interactions shape the therapeutic encounter in ways that are both unpredictable and subversive. By looking at how Guided Group Interaction diverges in theory and practice, I demonstrate that female residents adopt strategies of practice with particular end goals in mind and that this can result in moments of genuine collaboration as well as moments that go far beyond the intended scope of confrontation. I also argue that Guided Group Interaction as practiced ultimately resembles a form of confession in which residents are asked to be perpetually introspective but rarely are given the opportunity for healing or confirmation of personal transformation.

Chapter 5 continues the work of the previous chapter but does so by looking at a specific moment within Guided Group Interaction when residents and staff went off script and entered into a discussion about psychiatric diagnosis and psychotropic medication usage. I argue that new, psychiatric selves emerge at the point when conventional labeling fails and alternative explanations of behavior must be sought out. The chapter takes up instances of slippage between "real" selves, "medicated" selves, and "Bipolar" selves, looking at how female residents inhabit different labels and with what consequences.

In the Conclusion, I review the primary arguments that have anchored this study by turning to the processes of exit and transition. Thinking about how youth are discharged from Edgewood provides an opportunity to reflect on some of the key themes that I have explored in this study and to think more broadly about the position of female youth within residential treatment and juvenile justice systems in the United States. In so doing, I call attention to some of the policy implications that arise from this study.

CHAPTER 1
AMBIVALENT SPACES:
HISTORICIZING RESIDENTIAL TREATMENT FOR YOUTH IN THE UNITED STATES

This chapter situates Edgewood in time and space by exploring the historical roots of institutions for dependent and delinquent youth in the United States. I argue that residential care for children and adolescents embodies long-standing and deep ambivalence about how to respond to youth who do not conform to societal expectations of appropriate behavior. For the last two centuries, Americans have expressed two simultaneous and contradictory desires: to remove youth from the community in order to rehabilitate and then return them. On the one hand, public fears about violent, nonconforming youth have long motivated efforts to remove such youth from communities in the name of public order and safety. On the other hand, there remains a profound commitment to the ideal of rehabilitation in youth and to the belief that children and adolescents are amenable to change. Increasingly, these two projects—removal and rehabilitation—are presented as either/or scenarios; youth are portrayed as being either beyond help and in need of institutionalization, or worth saving and deserving of community-based interventions. In this scenario, residential care is associated with warehousing youth—a place of "last resort."[1]

Yet, such binary thinking excludes from consideration a more meaningful analysis of how residential treatment for youth has developed over time and obscures the contradictions that are embedded in the institutionalization and treatment of youth. By examining some of the key trends in the history of residential treatment for young people, this chapter broadens existing discussion about residential treatment along three directions. First, I demonstrate that the treatment of diverse groups of children—from dependents to delinquents—has long been

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1. Residential care, of course, involves only the *temporary* removal of youth from their homes. The implications of "temporary confinement" will be picked up in chapter 2.

intertwined and that movements to address such groups have largely proceeded apace. Second, I show how 20th century legislation and social movements created two discordant trends in child welfare—one to keep youth within homes and another to "get tough" and criminalize them. Third, I explore how New York State and New York City embody the ambivalence toward residential treatment in particularly emblematic ways. This leads to a discussion of how Edgewood fits into the space of residential treatment today. My aim throughout the chapter is to assert that past and present rhetoric masks enduring ambivalence about how to respond to youth who cross a threshold of socially acceptable behavior.

CREATING THE ASYLUM

As described in the introduction, there is considerable confusion today about how to define residential treatment and how to set the parameters for who is served in congregate care arrangements; residential treatment can refer to a wide range of settings—from group homes to large institutions—and may include youth from a variety of systems—from youth in foster care, to those in the juvenile justice system, to those in need of special education services. Within the recent literature on residential treatment, there have been calls to develop a clear definition for what is subsumed under the heading of "residential treatment" (Whittaker 2000; Butler and McPherson 2007; Child Welfare League of America 2007; Lee 2008; American Association of Children's Residential Centers 2009). Rarely, however, do such calls reference the history of residential treatment for youth in the United States or call attention to the established practice of treating diverse youth in the same setting.

David Rothman's (1971) work, *The Discovery of the Asylum: Social Order and Disorder in the New Republic*, provides the necessary social context for understanding how efforts to institutionalize diverse groups of people coalesced at a specific moment in history. Examining

the sudden and precipitous rise of institutions for deviant and dependent members of the community during the first half of the 19ᵗʰ century, Rothman disputes traditional perspectives that claim institutionalization was a method for regulating the work force or a concomitant of economic and demographic changes (1971:xvi-xvii). Rothman argues that the fact that prisons, poorhouses, orphan asylums and houses of refuge (i.e., reformatories) all "grew up" at the same time suggests broader considerations were at work; all of these institutions were created in reaction to a specific set of social conditions and with a particular goal in mind. Rothman writes:

> The response in the Jacksonian period to the deviant and the dependent was first and foremost a vigorous attempt to promote the stability of the society at a moment when traditional ideas and practices appeared outmoded, constricted, and ineffective. The almshouse and the orphan asylum, the penitentiary, the reformatory, and the insane asylum all represented an effort to ensure the cohesion of the community in new and changing circumstances… the asylum, they believed, could restore a necessary social balance to the new republic, and at the same time eliminate long-standing problems [Rothman 1971:xviii]

Underpinning these beliefs was a new emphasis on the idea that humans were born innocent and that sources of corruption were external to the individual. The family and community thus became a central focus for reform, and delinquent children especially came to be seen as casualties of their upbringing.

Residential treatment for youth went from being a relatively unknown practice in colonial America to a widely practiced one in the first half of the 19ᵗʰ century. Between 1830 and 1860, the number of orphan asylums in the United States expanded from 33 to 200 (Courtney and Hughes-Heuring 2009:175).[2] At the same time, houses of refuge were appearing in various states, with the first one—the New York House of Refuge—established in Manhattan in 1825. A closer examination of "orphan asylums" for dependent children and "houses of refuge" for delinquent children makes clear that there was little to distinguish these types of institutions. To

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2. The institution that is now Edgewood was created in the early 1800s. However, I have chosen to omit the particular details of its founding in this study in order to ensure the anonymity of the institution.

start, these institutions were founded upon similar ideals of "saving" children from "corrupting" influences (especially those attributed to lower-class families at the time such as drinking, begging, and roaming the streets) (Platt 1969). Optimistic about the malleability of youth, the philanthropists who were at the center of these institutions "shared an intense faith in the rehabilitative powers of a carefully designed environment" (Rothman 1971:206). Like orphan asylums then, houses of refuge were modeled after sanctuaries, "combining love and guidance with firmness and restraint" (Platt 1969:54). In both cases, the founders claimed that children were being removed from their homes for their own welfare; reform and refuge were synonymous.

In addition to sharing similar rehabilitative ideals, houses of refuge and orphan asylums also served similar populations. An 1858 study of the New York House of Refuge showed that only 38 percent of its children had broken the law; 61 percent were merely "bad" or "unfortunate" (Courtney and Hughes-Heuring 2009:176). Because the House of Refuge believed its mission was to save "predelinquent" youth, as well as children who had already committed delinquent acts, there were few specific admission criteria for reformatories. In many cases, both types of institutions became "convenient" places to hold lower class and foreign-born children (or the children of foreign-born parents). As Rothman writes, "The asylum and the refuge were two more bricks in the wall that Americans built to confine and reform the dangerous classes" (1971:209-210).

That the rhetoric of these "child-saving" institutions did not match up with reality has been the subject of several critiques (Courtney and Hughes-Harding 2009; Fox 1970; Pickett 1969; Pisciotta 1982; Platt 1969; Rothman 1971). In particular, it has been noted that although the institutions were not supposed to be places of penal retribution, much of their work was

characterized by coercion and restraint, with "corrective methods" such as indeterminate sentences, corporal punishment, and contract labor customary. One of the ways this work was accomplished was to abrogate parental authority; most superintendents of orphan asylums and houses of refuge insisted that parents transfer all rights to them upon their child's admission.

The power to act *in loco parentis*—known legally as the doctrine of *parens patriae*—was borrowed from the English legal system and incorporated into the American legal structure through an 1838 ruling in the state of Pennsylvania known as *Ex parte Crouse*. In response to a father who claimed that his daughter, Mary Ann Crouse, had been committed illegally to the Pennsylvania House of Refuge because she had not been granted a trial as a result of her age, the state Supreme Court decided unanimously that the Bill of Rights did not apply to minors. They reached this opinion by invoking the doctrine of *parens patriae*: "May not the natural parents, when unequal to the task of education, or unworthy of it, be superseded by the *parens patriae* or common guardian of the community?" (Pisciotta 1982:411). This operating principle became the legal and moral foundation of the first juvenile courts (Illinois created the first Juvenile Court in 1899; the founding of the Manhattan Children's Court followed in 1902). Although such courts were created with the intention of separating children from adults and decriminalizing delinquency, few steps were taken to ensure the full breadth of legal rights for children. As Platt writes in his work, *The Child Savers: The Invention of Delinquency*, "Since the child savers professed to be seeking the best interests of their wards, there was no need to formulate legal regulation of the right and duty to treat in the same way that the right and duty to punish had formerly been regulated. In effect, the new penology reified the dependent status of children by disenfranchising them of legal rights" (1969:67). *Parens patriae* would be supported through

successive legal decisions that allowed for the relaxation of procedural safeguards well into the second half of the 20th century.

RESIDENTIAL TREATMENT COMES OF AGE

Rothman (1971) suggests that asylums began to decline toward the end of the 19th century as rehabilitative ideals gave way to functional custodianship and the conditions of institutions took on increasingly punitive tones. At the same time, Rothman admits that the decline of the refuge was not as precipitous as other institutions because it sustained a much better reputation than the penitentiary. Officials and philanthropists maintained hope that the refuge could succeed with juveniles where other institutions—with older, experienced criminals—could not (Rothman 1971:257). Still committed to the ideal of rehabilitation, and cognizant of the pragmatics and convenience of institutional care, youth in the United States were still being sent to institutions regularly as the country entered the 20th century.

Meanwhile, there was another trend that ensured the continuance of residential care for children, albeit in a different form. As the medical field began to address mental illness directly in the early 1900s, child psychiatry emerged as a specialty and new institutions were erected to deal with behavior disorders.[3] Many of these early institutions were hospital based. For example, the children's psychiatric unit at Bellevue Hospital in New York City, the Franklin School in Philadelphia, and children's institutes at Allentown and Kings Park State Hospitals were all established in the early 1920s. The focus on children with primarily behavior problems remained standard, however. Most children admitted to these hospitals displayed aggressive behavioral

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3. Zimmerman (1990:10) lists significant milestones of the child psychiatry movement in the United States: the publication of the Binet intelligence scale (1905); William Healy's founding of the Chicago Juvenile Psychopathic Institute (1909); the founding of child-guidance clinics throughout the country by the National Committee for Mental Hygiene (1922); and the writing of the first textbooks on child psychiatry (1935) and child psychotherapy (1942).

problems rather than mental deficiencies, brain damage, or psychosis. When, in 1937, Bellevue established the first medically supervised unit exclusively for adolescents in a psychiatric hospital in the United States, children's court judges referred the majority of youth for offenses such as truancy, stealing, and running away (Zimmerman 1990:13-14).

Prior to the 1950s, most children and adolescents admitted to inpatient psychiatric treatment were placed among the existing adult-patient population. Increasingly, however, there were calls for developing special treatment units exclusively for adolescents. In such an environment the concept of a "therapeutic milieu" found traction. "Therapeutic milieus" were influenced strongly by psychoanalytic theories, with early contributions from Aichhorn (1935) and Anna Freud (1969) and later work by a number of pioneers (Bettelheim 1950, 1955; Bettelheim and Sylvester 1948; Redl 1959; Redl and Wineman 1951; Treischman et al. 1969). These environments were distinguished by their commitment to incorporating psychotherapeutic concepts into the structure of the facility and into the behavior of childcare staff. It was during this period that "residential treatment" gained currency as a term and the American Association of Children's Residential Centers (AACRC) was founded (1956). Although residential treatment centers today adopt a variety of therapeutic approaches—from psychoanalytic, to behavior modification, to positive peer culture—most remain committed in theory to creating a "therapeutic milieu" in which to treat youth with behavioral and emotional problems.[4] Edgewood is part of the AACRC and the legacy of work on "therapeutic milieus" has had a strong influence on its organization and operating principles.

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4. It is worth noting briefly that as "residential treatment" has developed over time, it has gained different connotations according to social class. The type of "residential treatment" discussed in this study is almost exclusively for the poor and is understood as a placement option for youth with "serious behavioral disorders." For middle and upper-class families in the United States, however, "residential treatment" is generally associated with mental health problems such as addictions, eating disorders, and depression. Access to private health insurance must be part of this discussion since it determines what types of residential treatment facilities are available to what individuals.

PRIVILEGING THE "HOME"

Just as confidence about the future of residential treatment centers was rising between the 1950s and 1970s, a number of contradictory trends occurred in the field of child welfare that would eventually displace residential treatment as a primary option for dependent and delinquent youth. The first of these trends was a distinct shift to privilege home environments for children over other living arrangements. This shift had both ideological and political underpinnings. On the ideological side, the idea that children should be kept at home had long been voiced in child welfare circles. At a 1909 White House Conference for the Care of Dependent Children, for example, attendees declared, "home life is the highest and finest product of civilization" (Courtney and Hughes-Heuring 2009:177). Meanwhile, privileging the home gained new momentum in the 1960s and 1970s as the deinstitutionalization of other populations (e.g., the mentally ill, the developmentally disabled) occurred in response to criticism about the efficacy of long-term hospitalization and as a "permanency planning movement" for children coalesced. Within the permanency planning movement, child advocates worked to ensure that child welfare agencies made every effort to assist families prior to removing a child from the home and that they actively planned to find children permanent homes when they had to be removed (Courtney and Hughes-Heuring 2009:181).

A preference for keeping children in homes was not merely ideological, however; it took on political currency through a series of legislative acts. The federal government's creation of Aid to Dependent Children as Title IV of the Social Security Act (1935) set up mechanisms to keep children out of institutions. By entitling families to receive aid directly for the first time, the act ensured there would be reduced need to institutionalize children for purely economic reasons (Courtney and Hughes-Heuring 2009; Leichtman 2007). Indeed, children were not eligible for

federal aid *unless* they lived with a parent or other close relative (U.S. Dept of Health and Human Services 1998:4). Much later, in 1980, the Adoption Assistance and Welfare Act (Public Law 96-272) again made clear the preference for home environments by requiring states to make "reasonable efforts" to prevent placements and reunify children with their families and to place children in the "least restrictive" and most "family-like" settings (Courtney and Hughes-Heuring 2009:182). As Courtney and Hughes-Heuring state, "The law made no mention of long-term residential care given that the very idea was anathema to the principles of permanency planning" (2009:182). Subsequent changes in federal child welfare policy, such as the Adoption and Safe Families Act of 1997, have continued to promote the ideals of permanency planning and give little attention to residential settings.

CRIMINALIZING YOUTH

Curiously, at the very same time that institutions were being criticized, many states began passing increasingly harsh legislation for youth that made it easier to institutionalize them for a variety of crimes. To begin, two landmark United States Supreme Court cases in the late 1960s were enormously influential in changing the face of the juvenile justice system, albeit in unexpected ways. First in *Kent v. United States* (383 U.S. 541 [1966]) and then more forcefully in *In re Gault* (387 U.S. 1 [1967]), the Supreme Court ruled that juveniles had constitutional rights to due process under the 14th amendment. In so doing, the Court raised a strong challenge to the doctrine of *parens patriae*, suggesting that constitutional rights could not be abrogated in the name of protecting youth. Delivering the majority opinion of the Court in *In re Gault*, Justice Fortas wrote, "Juvenile Court history has again demonstrated that unbridled discretion, however benevolently motivated, is frequently a poor substitute for principle and procedure." Ironically, even as *In re Gault* was hailed by many as presaging a new period of reform that would restore

legal rights to the young, the restoration of these rights made it easier to treat youth like adults and ultimately to try them in criminal courts. As Justice Stewart concluded in writing the single dissenting opinion in the case, concluded, the court's opinion served "to convert a juvenile proceeding into a criminal prosecution."

An examination of legislation introduced in the years immediately following these Supreme Court decisions suggests that many were eager to move away from a more benevolent justice system for youth. As crime rates rose nationally during the 1960s and 1970s, mandatory minimum sentences for juveniles were created, as were new laws requiring waiver to adult court and mandatory placement in secure facilities (Fagan 2010:45). In New York, for example, the legislature passed the Juvenile Justice Reform Act in 1976 and the New York Juvenile Offender Act in 1978. The Juvenile Justice Reform Act established the category of "designated felony" and stipulated that children above the age of 14 who were found to have committed such felonies could be placed for a period of three to five years (as opposed to the normal 18 months). Two years later, the New York Juvenile Offender Act lowered the age of criminal responsibility from 16 to 14 for a wide range of crimes (first and second-degree robbery and burglary, first-degree assault and rape, arson and kidnapping) and to the age of 13 for murder; all youth charged with these crimes were automatically tried in adult criminal courts. Both of these laws essentially created statutory exceptions to the Family Court Act of 1962 that had set the definition for a "juvenile delinquent."[5] Such "get tough" measures were mirrored across the country well into the 1990s as states developed numerous strategies to increase punishment amidst a broader turn to

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5. The Family Court Act of 1962 defined a "juvenile delinquent" as follows: "'Juvenile delinquent' means a person over seven and less than sixteen years of age, who, having committed an act that would constitute a crime if committed by an adult, (a) is not criminally responsible for such conduct by reason of infancy, or (b) is the defendant in an action ordered removed from a criminal court to the family court pursuant to article seven hundred twenty-five of the criminal procedure law" (§ 302.1). This definition excluded "status offenders" (i.e., youth who are "habitually disobedient") who, for the first time, were put into a new category called "Persons in Need of Supervision" (PINS). Further information on PINS appears in chapter 2.

neo-liberal forms of governance across the globe. Notably, New York has preserved one of the "toughest" stances on juvenile crime since this time: it is one of only two states in the entire country that has maintained its age of criminal responsibility at 16 (the other state is North Carolina; in most states, the age of majority is 18).

Impact on Out-of-Home Placements for Youth

One might imagine that getting tough on juvenile crime through statutory changes would have had the effect of increasing juvenile correctional confinement. It did. The number of cases adjudicated delinquent that resulted in out-of-home placements increased 42 percent nationally between 1985 and 2007 (placement rates rose 69 percent between 1985 and 1997 and then declined by 16 percent through 2007). The likelihood that an adjudicated case would result in placement was still 25 percent in 2007 (Puzzanchera et al. 2010:50-51). Yet, as Jeffrey Fagan (2010) argues, the increase in correctional confinements did not happen exactly as expected. First, the increase in placements for youth was minimal in comparison to the sharp increase in youth arrests during those years and paled in comparison to the increase in adult correctional populations during the same time period (2010:48). Thus, even if the number of youth sent to institutions increased, the increase was not as large as one might have assumed. And, as arrests for youth decreased after 1997, placements declined as well (though not as quickly; placement rates declined 26 percent between 1997 and 2008, while arrests declined 33 percent (Sickmund 2010:2)).

Second—and more importantly for understanding changes in residential treatment—even as states were getting tough on juveniles, they were simultaneously moving away from "warehousing" youth to embrace smaller, more therapeutic environments for juvenile delinquents beginning in the late 1990s (Fagan 2010:49). Fagan suggests that this trend is

evidence of legislators' continuing ambivalence about how to treat juveniles who commit crimes.

He writes:

> We believe deeply in child-saving, yet we are quick to expose violent children to the harshest punishments in service to the same punitive instincts that drive mass incarceration of adults. But even there, we pull our punches. We pull back from the brink of fully embracing punitiveness toward juveniles, reserving it instead for adults. Not only is the philosophy of child-saving an important normative modifier of these instincts, it is also deeply embedded in the institutions of juvenile justice and juvenile corrections. [Fagan 2010:49]

The result of such ambivalence is that while secure facilities for juveniles who commit the most serious crimes remain in abundance in the United States—nearly 200,000 youth were held in long term secure facilities in 2007 (Sickmund et al. 2011)—residential treatment facilities now make up the largest proportion of all types of facilities holding juvenile delinquents (34 percent in the most recent census, conducted in 2008) (Hockenberry et al. 2011:3). Furthermore, the majority of facilities (53 percent) are now privately operated (generally by not-for-profit agencies licensed by the state) and over one-third of juvenile delinquents are held in facilities with 50 or fewer residents (Hockenberry et al. 2011:5).

Unfortunately, the national statistics that are now collected regularly leave much to be desired and add significantly to the confusion about residential treatment. The United States Office of Juvenile Justice and Delinquency Prevention began administering the Juvenile Residential Facility Census (JRFC) in 2000 with data collections occurring every other year. This survey alternates with the Census of Juveniles in Residential Placement (CJRP), which collects detailed information on all youth held in residential placements on a specific reference date. Both surveys compile data directly from facility administrators, who self-identify the facility's characteristics. Comparing data is difficult, however, because facilities are allowed to select more than one facility-type category and it is not clear that the two surveys use the same

definitions of placement type. For example, whereas the CJRP distinguishes a short-term detention center from a long-term secure facility, the JRFC does not make this distinction. And, whereas the CJRP does not have "residential treatment center" included as a type of facility, the JRFC does (see Sickmund et al. 2011 and Hockenberry et al. 2011). Finally, none of the data collected reveal whether the facilities surveyed hold juvenile delinquents only or whether they, in fact, have mixed populations as Edgewood does (foster care youth, juvenile delinquents, special education students, etc.). At least at the national level, then, the scope and character of residential treatment remain ambiguous.

NEW YORK: A CASE STUDY OF THE JUVENILE JUSTICE SYSTEM

Turning away from national trends in juvenile justice and toward more local expressions of ambivalence about juvenile delinquents, a detailed examination of recent developments in New York State and New York City reveals a particularly murky ground where contradictions abound. A focus on New York is necessary, first, because the state has long claimed to lead the way in the area of juvenile justice, and, second, because Edgewood as an institution is profoundly shaped by developments at the state and local level. It is only by understanding the specifics of juvenile justice in New York that one can begin to understand the type of place that Edgewood is today.

The New York State Office of Family and Children Services (OCFS) is in charge of all youth who are adjudicated juvenile delinquents or juvenile offenders and placed in state custody. That is, when a youth is adjudicated and the judge orders a disposition (i.e., sentence) of placement, the youth is transferred from local custody to state custody. Youth can then be placed in a variety of facilities, some state-operated and others privately run. Service settings range from

"secure," to "limited secure," to "non-secure" in terms of level of restriction. Table 1 shows a comparison of the population admitted to OCFS statewide in 2000 and 2009.

Table 1 Characteristics of Admissions to OCFS Custody, 2000 v. 2009

	2000		2009	
	n	*%*	*n*	*%*
Total Admissions	2518	100.00	1468	100.00
Males	2124	84.35	1237	84.26
Females	394	15.65	231	15.74
Race/Ethnicity				
African American	1433	56.91	836	56.95
Asian	21	0.83	9	0.61
Latino	644	25.58	389	26.50
Native American	8	0.32	2	0.14
White	386	15.33	149	10.15
Other	26	1.03	39	2.66
Not specified	--	--	44	3.00
Prior Custody Status				
First OCFS custody	2396	95.15	1341	91.35
Prior OCFS custody	122	4.85	127	8.65
Initial Service Setting				
Secure	194	7.70	196	13.35
Limited Secure	1191	47.30	319	21.73
Non-Secure	553	21.96	166	11.31
Voluntary Agency	539	21.41	756	51.50
Other	41	1.63	31	2.11

Source: New York State Office of Children and Family Services 2011

Two points are noteworthy about these data. First, the overall number of youth admitted to custody decreased 41.70 percent—from 2,518 to 1,468—during the decade. Second, the type of youth placements changed dramatically. Whereas "voluntary agencies" (i.e., private placements like Edgewood) accounted for only 21.41 percent of youth in 2000, they served over 50 percent of youth in 2009. An examination of developments at the state and local levels helps explain some of these changes.

State-Level Changes in Juvenile Justice

The major driver of changes in juvenile justice at the state level undoubtedly can be attributed to the fallout from a 2007 investigation by the Civil Rights Division of the United States Department of Justice (USDOJ). On December 14, 2007, the USDOJ initiated an investigation into four New York State juvenile justice facilities to determine if youth in these facilities were adequately protected from harm (in particular, from staff's use excessive force and inappropriate restraints[6]) and to address allegations of sexual misconduct (USDOJ 2009:1). The investigation was likely prompted by the 2006 death of 15-year-old boy after being restrained by a staff member at the state's Tryon Boys Residential Center (Feldman 2007). Releasing their findings in August 2009, the USDOJ reported evidence of multiple abuses violating youths' constitutional rights, including the "use of excessive force and inappropriate restraints" and the "failure to provide adequate mental health care and treatment" (USDOJ 2009:5,15).[7] New York State entered into a comprehensive agreement with the USDOJ in July 2010 as a result of the investigation whereby they agreed to implement remedial measures to ensure that juveniles are safe and receive the services necessary to meet their constitutional rights. Among other measures, the agreement details restrictions on the use of physical restraints, a requirement that youth be assessed immediately by medical staff if restraints are used, and provisions for adequate mental health care and the use of safe and clinically appropriate psychotropic medications (USDOJ 2010).

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6. OCFS' policy on physical restraints (definition: "physically restraining a resident and to physically hold or move a resident against his will from one place to another") limits "the use of physical restraint to exceptional circumstances when all other pro-active, non-physical behavior managements have been tried and failed" and also provides that "staff shall employ only the minimum amount of physical control necessary to stabilize the youth/situation." The USDOJ investigated allegations—and found evidence of—inappropriate use of restraints including an overreliance on the use of handcuffs for "anything from sneaking an extra cookie to initiating a fistfight" (USDOJ 2009:5).

7. The USDOJ reported finding "no systemic constitutional deficiencies" in the area of sexual misconduct (2009:4).

The specific measures highlighted in the USDOJ settlement are being implemented in conjunction with other changes at the state level that call for more sweeping reforms in juvenile justice. Many of these changes are recommendations from the Task Force on Juvenile Justice, a group launched by former New York Governor David Patterson in September 2008. Recognizing that during the 1980s and 1990s "New York largely abandoned its focus on juvenile justice rehabilitation and treatment in favor of an approach that responded to delinquent behavior with punitive sanctions and institutional placement," the Task Force report calls for major reductions in the use of institutional placement and reinvestment in communities, measures to reduce disproportionate representation of youth of color in placement, and methods to ensure that New York State operates a unified system of care that keeps all youth safe, whether in private or state-operated facilities (Task Force 2009:12-14). The recommendations are made on the basis of both philosophical and practical appeals.

On the philosophical side, the Task Force evokes long-standing rhetoric that children are best served in homes and communities, arguing that institutional placement can be detrimental to low-risk youth and can pose greater risks to public safety. They write:

> Exposed to negative peer influences in institutions, low-level offenders learn unhealthy, even criminal habits. Family relationships and community links, which are central to health youth development, can be undermined by the estrangement that accompanies placement, even in well-run residential placement… as a result, many formerly incarcerated youth are unable to resist the negative pressures they face upon returning home. [Task Force 2009:36]

Such language is powerful when one considers the abuses documented by the Department of Justice in some state-run facilities. But the language also collapses the various forms of placement into a single one associated with "incarcerated youth"; state-run facilities for the worst juvenile offenders are not distinguished from private facilities for youth who have committed only misdemeanors.

On the practical side, the Task Force assumes that New York State can reduce recidivism rates and also save money by treating youth in the community with evidence-based principles and practices (a growing trend in bureaucratic forms of assessment). They cite statistics from 1991 to 1995—the most recent available for New York State—showing that of nearly 10,000 young people released from the state's residential institutions during those year, 75 percent were re-arrested, 62 percent were re-convicted, and 45 percent were incarcerated within three years of their release (Task Force 2009:35). Such dismal statistics are then compared to a study from Washington State demonstrating that youth who participate in Multisystemic Therapy and Family Therapy can have reconviction rates up to 18 percent lower than those in institutional placement (Task Force 2009:36). The Task Force projects that New York State could save over $11 million by expanding the use of these alternatives to accommodate 15 percent of youth currently placed in juvenile facilities while simultaneously offering more effective treatment approaches (Task Force 2009:42).

The 2011-2012 Enacted Budget for New York State reflects some of the recommendations of the Task Force report and is a clear move away from residential placement of youth in the juvenile justice system. Under the budget, a new program—Supervision and Treatment Services for Juveniles Program (STSJP)—creates incentives for municipalities to use alternatives to detention and placement for low and medium risk youth. Municipalities will receive 62 percent reimbursement for STSJP expenditures (up to a capped amount) but will only receive 49 percent reimbursement for "eligible detention services."[8] Beginning January 1, 2012, all municipalities will also have to use a detention risk assessment instrument (RAI) approved by

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8. It is unclear what is considered an "eligible detention service" and, more specifically, if municipalities are eligible for reimbursement when youth are placed with private agencies like Edgewood. Prior to this budget, for example, New York City was reimbursed 50 percent for juveniles in OCFS-operated facilities but was responsible for the full cost of juveniles sent to private facilities (New York City Independent Budget Office 2008:11). I return to this point later in the chapter.

OCFS and courts will be required to consider the RAI when issuing a detention order (Carrión 2011:3). This final measure may be a move toward eliminating reimbursement entirely for detention services for youth who receive a "low risk" or "medium risk" rating on the risk assessment; Governor Andrew Cuomo's 2012 proposed budget would have eliminated automatic reimbursement and supported local detention costs for high risk youth only (Cuomo 2011:47). Despite the move to divert youth from institutional facilities, it should be noted that the budget still designates $38 million over the next two fiscal years to increase staffing and improve services in state-run facilities.

Local-Level Changes in Juvenile Justice

At the same time that changes are being made to juvenile justice policy and funding streams at the state level, significant local transformations are occurring within New York City's juvenile justice system. These changes have followed state trends and have been justified using similar philosophical and practical appeals. The first major change has been to place increased focus on creating "alternatives to detention" for youth prior to sentencing and "alternatives to placement" for youth who have been adjudicated as a juvenile delinquents.[9] For options prior to sentencing, the city has been using a new RAI to determine the likelihood that a youth will commit a new crime or fail to appear in court while his or her case is pending. Since 2008, probation offers have entered information correlated with these factors into a matrix to determine a risk score for any youth whose case is petitioned (i.e., prosecuted). Youth who score low on the matrix are deemed suitable for release with no formal supervision; youth who score high are deemed most suitable for detention; and youth with a medium risk score are eligible for

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9. The city uses the term "detention" to refer to both secure and non-secure facilities for alleged juvenile delinquents and juvenile offenders whose cases are pending. In contrast, the term "placement" is used when an adjudicated delinquent is ordered to confinement by a judge at the dispositional hearing.

supervision by the city's new alternative-to-detention programs, including "community monitoring," "after-school supervision" and "intensive community monitoring" (Fratello et al. 2011:10).

For dispositional options, judges are being urged to consider alternatives to placement such as the Enhanced Supervision Program which provides community-based, family-centered supervision; Esperanza, a project of the Vera Institute for Justice which provides individual and family counseling in lieu of placement; and the Juvenile Justice Initiative (JJI), the city's most recent alternative-to-placement service. JJI has received considerable attention because the city has budgeted roughly $11 million to the initiative. In addition to having alternative-to-placement slots, JJI includes aftercare slots for juveniles returning from placement. A pilot project aimed at reducing the average length of stay in facilities for youth who are placed (from 12 months to 6 months) has also been started in the Bronx and in Queens (New York City Independent Budget Office 2008:11).

In addition to increasing alternatives to detention and placement, the city has made a more symbolic change in its approach to juvenile delinquency by merging the juvenile justice and child welfare systems. In January 2010, Mayor Michael Bloomberg announced that the Department of Juvenile Justice would be integrated into the Administration for Children's Services in a new Division of Youth and Family Justice. This change is justified by the significant overlap in the populations served by juvenile justice and child welfare; a recent estimate of youth in New York City detention showed that 69 percent had either current child services contact or a history of contact (NYC ACS 2010:9). But it has also been billed as the next step in the city's juvenile justice reform. As John Mattingly, Commissioner of the Administration for Children's Services until July 2011, described in his testimony to the City

Council, "With the integration… the City enters into the next phase of our juvenile justice

reform. We will continue to work with our sister agencies to move our system forward with the

goals of maintaining public safety and reducing recidivism, while providing the best care

possible for court-involved youth in the least restrictive setting possible" (Mattingly 2010:5).

Just as the rhetoric at the state level works to reduce or remove residential placements from the

service continuum for juvenile delinquents, so too does the rhetoric at the city level show a

strong preference for keeping youth in the community.

Of course, there are also financial considerations that have motivated these changes:

placing youth in detention while their cases are pending or placing them in facilities once they

are adjudicated delinquent is extremely costly. A 2008 report by the New York City Independent

Budget Office (NYCIBO) stated that the total cost of providing juvenile justice increased from

$202 million in 2003 to an estimated $251 million in 2007. This rise in spending was driven

largely by increases in detention and placement costs, which consume more than 75 percent of

the city's spending on juvenile justice (NYCIBO 2008:1). Notably, the city is responsible for

paying OCFS half of the cost of placement in state-operated facilities, but it is responsible for

covering the entire cost of juveniles sent to private facilities like Edgewood. Thus, even though

the number of dispositions resulting in placement has declined in recent years, the costs to the

city have not diminished because the proportion of youth in private placements has increased

(NYCIBO 2008:11). The NYCIBO report urged the city to create effective alternatives to

detention and placement for immediate and long-term cost savings, citing the differential average

cost for a youth who is placed in a facility ($119,483) versus a youth who is placed in Esperanza

($26,250) or in the Enhanced Supervision Program ($2,708) (NYCIBO 2008:9).[10]

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10. The NYCIBO Report does not state clearly that part of the cost differential in these programs is related to the
length of time they are designed to last. Youth placed in a facility are generally placed for one year. By contrast,

A System in Limbo

The changes to New York's juvenile justice system just described offer clear evidence that the state and city are moving away from detention and placement of youth in favor of potentially more effective and less costly community-based alternatives such as Esperanza and the Enhanced Supervision Program. Given the findings from the Department of Justice investigation, it is understandable that lawmakers and advocates in New York are shying away from residential treatment for youth who commit crimes. Even if there is a clear need for ongoing reform to the juvenile justice system, however, the tendency to associate the placement of youth with the harshest conditions of confinement diminishes attention to other questions that deserve to be asked in regards to treating youth who end up in the juvenile justice system. I point to three such questions here.

First, what explains the substantial increase in the proportion of youth sent to private residential placements (i.e., placements run by not-for-profit organizations like Edgewood rather than the state)? The cost-sharing arrangements indicate that this shift is likely not being driven by financial considerations. And there are no data yet comparing the outcomes for youth who are discharged from state-run facilities versus private facilities (the Task Force found that the state's contracts with private agencies do not require the agencies to track data on their program operations or report on their performance measures) (Task Force 2009:82). More data are clearly necessary before denouncing residential treatment altogether. Given that judges are the ultimate arbiters of where youth are placed, research should assess the factors involved in judicial decision-making. Until then, it is likely that private residential placements will continue to be in demand as service settings for youth in the juvenile justice system.

Esperanza is designed to last four to six months (Esperanza 2011) and the Enhanced Supervision Program is designed to last nine months (NYC Department of Probation 2011).

Second, is there enough evidence to conclude that alternatives to detention and placement lead to better outcomes? Most of the city's programs are in their nascent stages and preliminary outcomes may overstate the success. For example, the Vera Institute reports that since implementing its risk assessment tool there has been a 30 percent reduction in the rate of re-arrest for youth during the time their cases are pending (Fratello et al. 2011:13). Yet, this reduction may be due in large part to the fact that the risk assessment has led to a marked increase in the number of high-risk youth who are detained while their cases are pending (Fratello et al. 2011:12). Additionally, my research at Edgewood provided me with multiple examples of girls who had been placed in the Enhanced Supervision Program, Esperanza and JJI in the past only to end up at Edgewood later. It is clear that there is a subset of youth for whom these programs do not work and that the push to avoid placement may actually be counterproductive for some young people.

Third, what evidence base is motivating JJI to work with private facilities in reducing the length of stay for youth (generally from 12 months to six)? Governor Patterson's Task Force cites one literature review (Hair 2005) that discusses a correlation between shorter lengths of stay and treatment outcomes but fails to mention that the studies did not include adjudicated youth (only youth with histories of behavioral and emotional problems). Practically speaking, six-month stays put enormous pressure on agencies like Edgewood to "change" youth in a very short time period—an issue that will be discussed further in chapter 3. Furthermore, shorter stays mean more frequent disruptions in other areas of a young person's life, including their education.

CONCLUSION: LOCATING EDGEWOOD IN POLITICAL AND CULTURAL SPACE

The purpose of this chapter has been to contextualize Edgewood in time and space by examining historical trends in the treatment of dependent and delinquent youth in the United

States. "Child-saving" institutions have found a permanent place in the American child welfare landscape for nearly two centuries even as the motivations for erecting and maintaining them have changed over time. If the "asylum" came of age in the first half of the 19th century to restore social order, by the end of that century it was also a convenient holding place for nonconforming members of society. And, if policy began to move away from residential placements in the 1960s and 1970s, other trends in crime and juvenile delinquency have ensured that such institutions will never be fully eclipsed. I have suggested that these diverse trends reflect underlying ambivalence about how to respond to youth who do not conform to societal expectations of appropriate behavior. We desperately want to believe that youth can change and yet we remain unsure about the best way to achieve such change.

This chapter also focused on the trajectory of New York's juvenile justice system because the local context is equally, if not more, important for understanding Edgewood today. I have argued that New York is particularly emblematic of our ambivalence about misbehaving youth. The state is home to the nation's first house of refuge but it is also maintains some of the harshest contemporary legislation for youth and is one of only two states that still considers legal adulthood to begin at age 16. Only in recent years—amid charges of abuse and rising costs—has New York started to reevaluate its juvenile justice system and, with it, the place of residential treatment in the spectrum of services for troubled youth. Even so, residential treatment centers like Edgewood have a nearly limitless supply of youth and the effectiveness of alternatives has yet to be tested rigorously. Lest one thinks that residential treatment centers will fall by the wayside quickly, one needs only to pay attention to the structure of union contracts and to

political constraints from lawmakers who fear the loss of jobs that would be entailed by closing facilities.[11]

Places like Edgewood often recede into the background of debates because they do not fit neatly into one category of child welfare. Crossing boundaries between foster care, juvenile justice and special education, Edgewood exists "in-between," having adapted over time to meet the meet the needs of a state that both loathes and clings to residential treatment at the same time. Embedded in a larger environment where there is growing consensus that children are best served in their home communities, Edgewood exists because there is a continuing need for places that will treat youth who are unable to live at home—whether because they are abused or neglected, because they have unmanageable behavioral and emotional problems, or because they have committed crimes and other interventions have failed.

While the historical record can tell us much about the genesis of Edgewood and the deep roots of the debate about how to best serve troubled youth, it stops short of providing an understanding of what Edgewood is like today—as a place to live and to change oneself. For this, we must return to the ethnographic record of Edgewood and to a more vivid description of Edgewood residents, their diverse paths to the campus, and their everyday lives at the institution. In the next chapter, I embrace this task by moving away from the debates occurring outside the institution to examine how life unfolds on the inside.

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11. Most of the press on this issue has been dedicated to discussion of state-run facilities (Dwoskin 2010; Rodriguez 2010). Given that Edgewood's childcare workers are unionized too, however, it is easy to see how objection to closing down facilities may ultimately cover private and public institutions.

CHAPTER 2
"THE 'HOOD PART 2": LIVING AT EDGEWOOD

This chapter introduces the reader to the multiple referral sources through which youth come to Edgewood (juvenile justice, foster care, special education), and to the physical space of the campus and its daily rhythms. Whereas chapter 1 illuminated the broader social, political, and economic contexts in which Edgewood has been situated over time, this chapter provides a more detailed examination of how youth get to the campus and what their lives are like once within it. My aim in this chapter is not merely to orient the reader to key categories and schedules, however. Rather, my goal in presenting this information is to suggest two further-reaching points about how Edgewood is constituted as a particular type of space for youth who cross a threshold of socially acceptable behavior. First, I argue that the classification of youth has important implications for institutional functioning as well as for how youth are perceived by staff and peers and perceive themselves in turn. Referral sources are linked not only to reimbursement rates for Edgewood but also to the psychiatric diagnoses female youth are given and to assumptions—often inconsistent—about behavior and clinical need. Second, I demonstrate that although residents at Edgewood are physically removed from their home communities and follow fairly regimented schedules, their daily routines are punctuated by outside influences that impact their perceptions of Edgewood as a place to live and their attitudes about the purpose of their time on the campus. I suggest that these perceptions and attitudes raise questions about the relationship between custody and treatment and entail assumptions about the locus of responsibility for personal transformation.

Given that residential treatment receives little support in the current political and economic environment, it is fair to say that Edgewood is a place of last resort for most youth. Whether because of a series of "failed" foster home placements, abuse or neglect from parents, delinquent activity, or behavioral and emotional needs, youth who come to Edgewood know that they are at the end of the line in terms of options for care. Nonetheless, because diverse city and state agencies oversee juvenile justice, foster care, and special education services, young people travel to Edgewood on distinct referral paths. As described in the introduction, Edgewood serves approximately 165 youth from four referral sources in New York: the New York State Office of Children and Family Services (OCFS; youth in the juvenile justice system); the New York City Administration for Children's Services (ACS; youth in New York City's foster care system); local Committees on Special Education (CSE; youth in need of special education services) and the local Department of Social Services in the county where Edgewood is located (DSS; youth in the local county's foster care system). Table 2 shows the population of Edgewood by referral source and gender as of April 2011.

Table 2 Population of Edgewood by Referral Source and Gender (April 2011)

Referral Source	Total Population	Percent of Total Population	Total Female Population	Percent of Female Population	Total Male Population	Percent of Male Population
OCFS	66	41	15	26	49	59
ACS	58	36	25	44	13	16
CSE	35	21	15	26	20	24
DSS	3	2	2	4	1	1
Total	162	100	57	100	83	100

A more detailed examination of the female population at Edgewood during my fieldwork appears in table 3 below. Table 3 shows a basic racial breakdown by referral source of the 100 female residents who lived at Edgewood between January 1, 2010 and October 31, 2010 (as

Table 3 Racial Breakdown of Female Residents at Edgewood (January – October 2010)

Race	OCFS (N = 41)		ACS (N = 45)		CSE (N = 11)		DSS (N = 3)		TOTAL (N = 100)	
	n	%	n	%	n	%	n	%	N	%
African American	26	63.41	29	64.44	6	54.55	2	66.67	63	63.00
Latina	11	26.83	12	26.67	3	27.27	1	33.33	27	27.00
African American & Latina	3	7.32	3	6.67	0	0.00	0	0.00	6	6.00
Caucasian	0	0.00	1	2.22	2	18.18	0	0.00	3	3.00
Asian	1	2.44	0	0.00	0	0.00	0	0.00	1	1.00

reported by the agency). These residents ranged in age from 11 to 20 (mean = 15.8, SD = 1.6).

Time spent at Edgewood varied by referral source. For residents discharged during this time

period, the range of time spent on the campus was between 46 and 2,014 days. Yet, whereas the

median number of days that OCFS residents spent on campus prior to discharge was 258 during

this period, the median number of days for ACS residents was 370, and the median number for

CSE residents was 342 (no DSS residents were discharged during my fieldwork).

The referral paths for each resident are described in detail below. I have chosen to include

a vignette of one OCFS resident and one ACS resident following the general description of those

referral pathways. The residents chosen are individuals who I came to know well during my

fieldwork. It would be difficult to choose any one resident who is particularly representative of

OCFS or ACS youth since there are so many ways that youth end up at Edgewood. However, I

do think that the cases selected speak to some of the common themes that I observed during my

research. I have not included vignettes of CSE or DSS residents for three specific reasons. First,

there were few CSE or DSS residents (five CSE, one DSS) at Edgewood during my research and

even fewer were living in Hamilton or Thayer Cottages. To write about any of these residents

anonymously would therefore be especially difficult. Second, the CSE residents who did live in

Hamilton or Thayer were transferred either in or out of the cottage during my fieldwork and four

out of five were hospitalized during the months they lived in those cottages. Both of these facts

meant I had limited time to get to know CSE residents. Finally, CSE residents are not discussed

in biweekly Rounds because their cases are reviewed in CSE-specific meetings. I thus have

limited data about CSE residents outside of any personal interactions and observation.

OCFS Residents – New York City Juvenile Justice

OCFS residents are those youth who have been adjudicated in the New York City

juvenile justice system and placed in the custody of the New York State Office of Children and

Family Services after being deemed a "juvenile delinquent"[1] by a Family Court judge. Figure 1

shows how the processing of a "juvenile delinquent" occurs within New York. When judges

decide to place a youth, the time of placement is most often a period of 12 months, although a

smaller group of youth at Edgewood is serving dispositions of 18 months. The actual time served

varies depending on whether a youth is eligible for the Juvenile Justice Initiative that allows for

early release dates with intensive aftercare services. Although providing a succinct snapshot of

this process, the path from arrest to placement at Edgewood is anything but straightforward.

Myriad factors influence the various turns this path will take, including the young person's

previous arrest and/or probation history, his or her home environment and living situation, and

the results of interviews and psychological evaluations.

It is clear that youth who are placed at Edgewood often have lengthy arrest histories even

if the crimes they commit are not at first considered particularly severe by the courts. In each of

the ten case records that I received permission to review, the mean number of arrests per resident

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1. The New York State Family Court Act §301.2.1 defines a "juvenile delinquent" as "a person over seven and less than sixteen years of age, who, having committed an act that would constitute a crime if committed by an adult, (a) is not criminally responsible for such conduct by reason of infancy, or (b) is the defendant in an action ordered removed from a criminal court to the family court pursuant to article seven hundred twenty-five of the criminal law procedure." This definition is separate from the definition of a "juvenile offender," which refers to youth who commit a crime while under the age of 16 and are tried and convicted in a criminal (adult) court due to the severity of the offense.

Figure 1 Flowchart of New York State's Juvenile Delinquency System
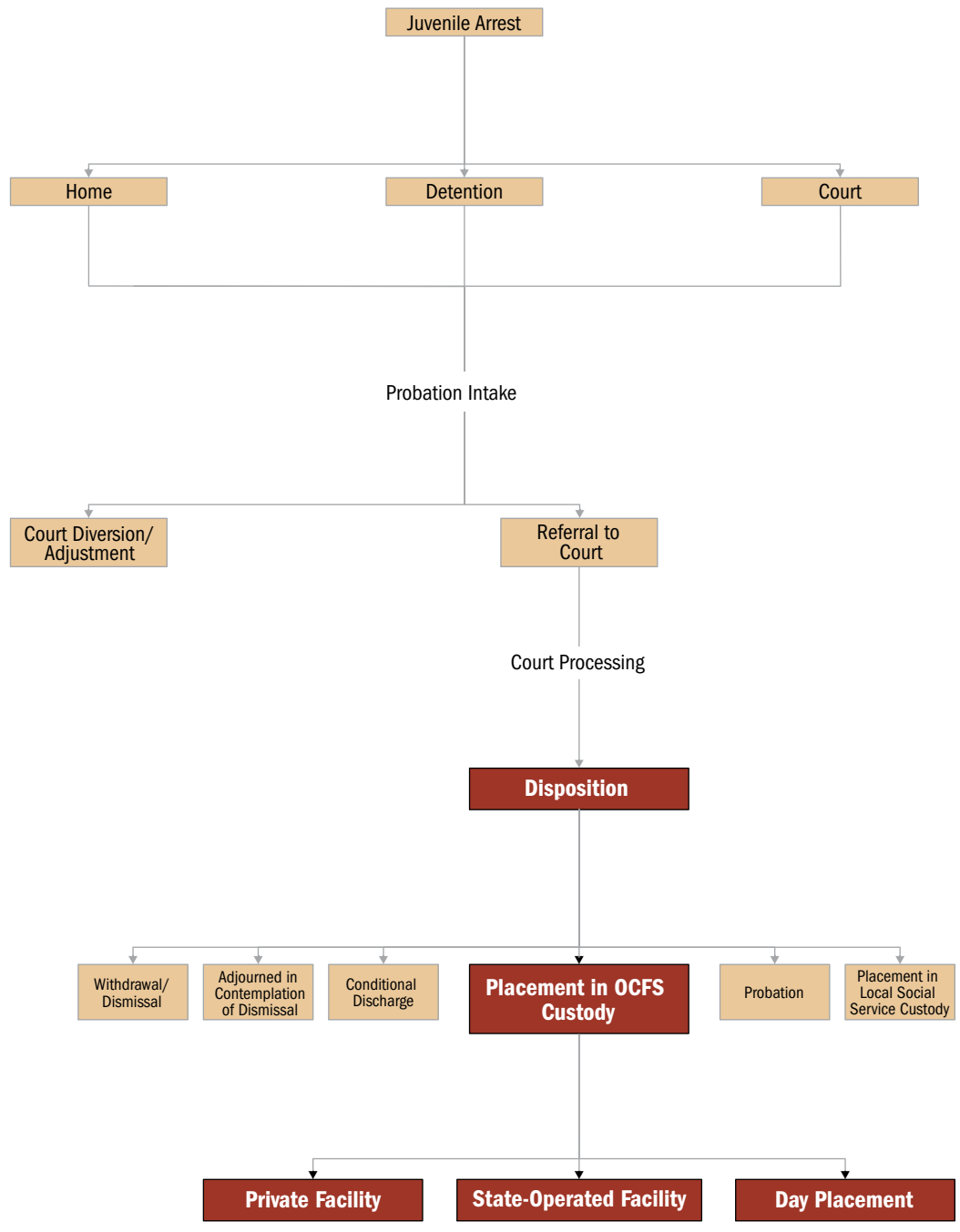
Source: Task Force on Transforming Juvenile Justice 2009

prior to admission to Edgewood was two (range = 1-4). The crimes for which these ten girls were arrested (and the number of arrests for each crime) were as follows: robbery (5), assault (4), criminal mischief (2), criminal possession of a controlled substance (2), criminal possession of stolen property (2), petit larceny (2), criminal trespassing (1), gang assault (1), making graffiti (1), and menacing (1). (See Appendix B for the legal definition of each of these crimes, including information on the degree of each charge that was given in these cases.)

What is interesting, however, is that these crimes are not what ultimately led to placement at Edgewood. In nine of the ten cases, the girls were given probation for their crimes and it was only in violating the terms of their probation that legal proceedings started that resulted in placement. For all of the current political fervor condemning recidivism rates of youth who have been sent to institutional facilities, little focus has been placed on the lack of viable community-based alternatives. And, because programs touted to work are still relatively new in New York, little information exists on whether such programs actually reduce recidivism. Indeed, many of the girls I interviewed had already been part of probation programs with little success.

In addition to the influence of arrest history in sending a young person to Edgewood, a series of written records affects a judge's final decision to place a child in state custody. Youth who are arrested in New York City are interviewed and assessed by the Department of Probation first, which decides whether an alleged juvenile delinquent should be referred to the prosecutor's office. Those youth who are "petitioned" then go through an arraignment proceeding and a fact-finding hearing before the judge decides on the relevant disposition. Prior to receiving a disposition, however, youth also receive a psychological evaluation from a court-appointed psychologist. The psychologist's report includes a *DSM* diagnosis and a recommendation for the judge on an appropriate disposition. For youth who are in the process of having probation

revoked, records will also include a history of reports from their probation officer and a

recommendation for action, as well as additional psychological evaluations. Not surprisingly, a

significant amount of paperwork follows youth during their time in the juvenile justice system.

That such paperwork regularly provides condemning portrayals of court-involved youth cannot

be overemphasized. An example from a probation report illustrates this:

> It is apparent that this respondent has no insight in regards to her self-destructive
> behavior and is unable or unwilling to use the tools given to her to help her correct her
> functioning in the community and in the home. It is also apparent that she has no problem
> making others the victims of her self rage, including her mother… it is felt that it would
> be counter productive to allow this respondent to remain in the community to victimize
> others and continue on her path of self-destruction.

A second example from a psychologist's evaluation of a different youth is equally negative:

> The respondent freely admitted that she ignored her probation restrictions because she
> simply did not believe, or could not imagine, that they would be enforced. Now that she
> faces the consequences, she indicated, the meaning of having probation was more clear to
> her and she would comply in the future. This is truly anti-social thinking, in which only
> tangible consequences matter and such intangibles as trust or good faith do not…
> Considering how violently she acted in the instant offence and how unresponsive she
> showed herself to be when confronted directly with evidence of consequences to her
> actions, it is believed that she poses a public safety risk moving forward.

Undoubtedly, these narratives are crafted in a specific way because they have a job to do:

they must capture the need for "reform" and thereby provide a warrant for placement. In both of

the records cited, emphasis is placed not only on the past and current behavior of the young

person, but also on her potential for future acts. Because judges only order placement when it is

considered to be in the "best interests" of the child and when "reasonable efforts" have been

made "where appropriate and consistent with the need for protection of the community, to

prevent or eliminate the need for removal of the Respondent from the home" (standard language

from court documentation reviewed), they must have sufficient evidence to justify their

placement decision. The negative portrayals of youth written by probation officers and court

psychologists thus have an institutional function that goes beyond what is written at a specific

time and place. Like Garfinkel's account of "good" organizational reasons for "bad" clinic

records, juvenile justice records contain "tokens" of information "like pieces that will permit the

assembly of an indefinitely large number of mosaics" (1967:202). When the time comes for a

judge to decide on a disposition, he can draw on these tokens to create his own understanding of

the case and rationalize placement on the basis that "reform" is needed.

It is important to note that the hearings, investigations, reports and evaluations at work in

the final decision to place a youth in state custody do not necessarily occur in short order; the

elapsed time from arrest to placement can take months. During my days at Edgewood, the

process of putting together a timeline of a single resident's case record—from first arrest to

placement at Edgewood—was byzantine, most often because the campus received incomplete

reports from the various agencies involved with the youth prior to placement (for example, case

records might be missing interviews from the probation department or documentation about

previous arrests). As I pieced histories together with the help of interviews, I was struck by the

enormous length of time that residents at Edgewood had been involved in detention even before

arriving at the campus.[2] On average, the residents whose cases I reviewed spent 116 days in

detention prior to arriving at Edgewood. These were not always consecutive days but often split

up over the course of many months; a youth might be detained after a fact-finding hearing, for

example, paroled home for some time or put on probation, and then detained again for a separate

incident or for violating probation. Thus, the elapsed time between first arrest to arrival at

2. Detention here refers to secure detention facilities and non-secure detention facilities that hold youth while their case is being processed. New York City has two secure detention facilities, Crossroads Juvenile Center in Brooklyn and Horizons Juvenile Center in the Bronx. The city also has a network of non-secure detention group homes located throughout the five boroughs, most of which are operated through contracts with private social service agencies. Until April 2011, all youth were processed at the city's secure intake center, Bridges (formerly Spofford), and then assigned to secure or non-secure detention. Bridges has since been shut down amid concerns that it did not provide adequate services and was an inhumane place to hold children (see Hirsch 2011).

Edgewood was actually much longer than the time spent in detention: an average of 378 days.

Over one year of juvenile justice involvement—all before the 12-month disposition these youth

are ordered to serve at Edgewood. Below, I detail Clarice's journey to Edgewood as one example

of how this process can unfold.

Clarice's Story

Clarice arrived at Edgewood in January 2010, having been given a disposition of 12

months for violating probation. African American and 16 years old, Clarice had been living with

her maternal grandmother and two siblings prior to admission. Her grandmother had been

granted legal custody of Clarice and her siblings after they were removed from their birth

mother's home due to abuse and neglect. Both of Clarice's parents have a history of

incarceration and substance abuse and her older brother was in detention when I interviewed her.

Clarice reported to me—and her case records confirmed—that she was first arrested in

March 2008 for criminal trespassing. She said that she and her friends were "never bad kids"

until the age of 13; at that time, she stopped going to her after-school program and started getting

in fights. Clarice was arrested several more times over the course of the next two years—for

assault, petit larceny, and criminal mischief. In each case, she was given probation and ordered

to take part in an alternative-to-detention program. And, in each case, she violated the terms of

the program and was ordered back to detention. Clarice attributed her probation violations to the

strict curfew at night, something that many other OCFS residents told me they had trouble

following. "I kept on violating [the terms of probation]," Clarice told me. "I went to everything

they want me to do, the psychologist and stuff. It's just the curfew. It's too early. 5:30 [p.m.]

sometimes 5:30, 6:00, 6:30. The latest they gave me was 7:00." In total, Clarice spent 189 day in

secure detention (across seven different admissions) prior to being admitted to Edgewood.

Despite her repeated arrests, Clarice was surprised when her judge finally ordered her to be placed at Edgewood. "This is the first time I got sentenced. My judge, like I think my judge really likes me, that's why. He believe… I can make it." The order of placement came as a sort of relief for Clarice, however. "I couldn't wait to leave [secure detention]," Clarice recalled. "When I was locked up I kept dreaming about this place, so I already knew I was gonna come here before they even said it… and I kept on dreaming about this cott [Hamilton Cottage]… so I really wasn't really upset. I was happy. I couldn't wait to come" (Interview, July 24, 2010).

Clarice's dreams about Edgewood underscore the reality that Edgewood remains a welcome escape for many youth. In comparison to the secure detention facility where she lived for more than six months, Clarice pictured Edgewood as a welcoming—if inevitable—placement. That Clarice's grandmother was also attempting to give up custody of Clarice around the time of our interview may have also influenced Clarice's perception of the campus (her grandmother told me, "I have decided to give them [Clarice and her sister] up. It's too hard."). Edgewood was a place that Clarice had dreamed of belonging to and her grandmother was simultaneously confirming that Clarice was not welcome at home.

ACS Residents – New York City Foster Care

By a slim margin, the majority of female residents who lived at Edgewood during my fieldwork were admitted through New York City's Administration for Children's Services, the agency responsible for foster care. The majority of these youth (approximately 75 per cent citywide in 2010) enter the system through child abuse and neglect petitions (NYC ACS 2011). Other paths include voluntary placement by a parent or designation as a "PINS" (Person in Need

of Supervision).[3] It is relatively rare, however, for foster care youth to end up in residential

placement: of the 14,459 New York City youth in foster care in June 2011, only 9 percent

(1,302) were in residential placement (NYC ACS 2011). Most foster care youth are placed with

family members in a Kinship Foster Boarding Home, or with non-relatives in a Regular Foster

Boarding Home or a Therapeutic Foster Boarding Home (for youth who are developmentally

disabled, have a history of "failed" placements, or are at high risk for group placement). Given

that residential placement is seen as a last resort when other placements have not been

successful, arrival at Edgewood is usually the latest stop on what has already been a long history

of being moved around to different homes. This is remarkably clear in Kimberly's story below.

Kimberly's Story

Kimberly, a 15-year-old Latina, was admitted to Edgewood from an adolescent

psychiatry unit of a city hospital in August 2010. Her entry into the child welfare system began

in 2007 when she made allegations against her mother for choking her and was subsequently

removed from her parents' care (notably, Kimberly was the only resident I came across during

my research whose birth parents were still married and living together). In the intervening three

years, Kimberly lived with two different relatives (a maternal uncle and a maternal aunt) and was

3. The New York State Family Court Act §712(a) defines a "person in need of supervision" (PINS) as "a person less than eighteen years of age who does not attend school… or who is incorrigible, ungovernable or habitually disobedient and beyond the lawful control of a parent or other person legally responsible for such child's care, or other lawful authority, or who violates the provisions of section 221.05 [unlawful possession of marijuana] or 230.00 [prostitution] of the penal law." PINS are "status offenders." Interestingly, the original PINS legislation from 1962 showed a distinct gender bias, setting the upper age limit of jurisdiction at 16 for boys and 18 for girls. The constitutionality of this was challenged in 1972, with the result that jurisdiction was limited to all youth under 16. In 2001, New York raised the maximum age of PINS jurisdiction from 16 to 18 (Souweine and Khashu 2001). There is lingering criticism that the legal language of PINS is biased against female sexual behavior (Poulin 1996:545). Additionally, the constitutionality of PINS legislation (in New York and elsewhere) has been challenged for being exceptionally vague (see Gardner 2010).

admitted to a Diagnostic Reception Center (DRC)[4] in Staten Island for several months. She was also been hospitalized on several occasions and diagnosed with Bipolar Disorder.

Kimberly described her problems as being related to her drug abuse. "I was doing perfectly fine before smoking weed," she told me. After beginning to "smoke weed" on her 14th birthday, Kimberly noted that "everything just started falling from there"—she stopped going to school, started drinking and smoking regularly, and eventually began using prescription drugs—Percocet and Oxycontin. Kimberly noted stealing money from her aunt to purchase them.

Although Kimberly's parents were unable to control her behavior and drug use, it appears that they were also ambivalent about her placement in a residential setting. During Kimberly's stay at the DRC, she disappeared from the residence frequently to stay at her parents' house. Then, when residential treatment at a place like Edgewood was proposed, her mother helped her evade foster care workers to avoid placement. Kimberly told me that her mother did not want ACS to send her to another placement so she advised Kimberly to pack her clothes and go live with her grandmother. "No one knew where my grandmother lived. It was hidden because my mother didn't want them to send me to a place like this," she told me.

Kimberly's mother regained custody for several months at this time but as Kimberly's drug use escalated her mother decided to obtain a mental hygiene warrant for Kimberly's arrest.[5] This led to a violent confrontation with police officers in which Kimberly reports that she "blacked out" and was trying to attack the police officers. A judge subsequently ordered

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4. A Diagnostic Reception Center is a temporary residential placement for youth with serious behavioral and emotional needs. A young person's needs are evaluated and placement options—whether back home or in a residential environment—are considered.

5. Article 9 of New York State Mental Hygiene Law details procedures for the hospitalization of mentally ill individuals. The "mental hygiene warrant" that Kimberly references here corresponds to §9.43, which states that judges can issue a warrant directing that a person be brought before the court if there is evidence "that a person is apparently mentally ill and is conducting himself or herself in a manner which in a person who is not mentally ill would be deemed disorderly conduct or which is likely to result in serious harm to himself or herself."

Kimberly to Bellevue Psychiatric Hospital while ACS found a residential placement for her. She stayed in Bellevue for approximately five weeks before being admitted to Edgewood.

CSE Residents – Special Education

CSE residents are referred to Edgewood because of emotional disturbances or disabilities that make it impossible for them to get adequate educational services in their home school districts. The school at Edgewood is one of 13 Special Act School Districts created by the New York State Education Department (NYSED) to serve students with such needs. In particular, the Edgewood school serves the following types of disability: Emotional Disturbances ("severe acting out behavior" and/or "fragile/psychiatric issue"); Learning Disabilities (with "emotional behavior secondary disability"); Multiple Disabilities ("challenging behaviors: aggressive, self-injurious"); and Other Health Impairments ("Tourette's syndrome/challenging behavior") (NYSED 2011a). Students go to school year-round. For a student to be placed in a residential educational program like Edgewood, the student's home school district must provide documentation that residential services are necessary to meet the student's educational needs, and also provide a timetable for enabling the student to return to a less restrictive environment (or a justification for why such a timetable is not appropriate) (NYSED 2011b). In reality, a CSE placement is the option of last resort for young people who fail to behave in school.

DSS Residents – County Foster Care

The final category of Edgewood residents includes referrals from the local Department of Social Services where the campus is located. The reasons for referral mirror those of ACS residents. As seen in Table 2, very few residents were referred from this source during my fieldwork. The Vice President of Edgewood told me there is an ebb and flow to the number of

residents coming from DSS, in part due to the fact that DSS is more difficult to work with because it has been in a state of transition for some time. It is possible that changes underway at DSS will result in more foster care residents from the county being placed at Edgewood.

IMPLICATIONS OF RESIDENT CATEGORIES

The referral paths described above may make it appear like the populations at Edgewood are distinct. To the contrary, the residents in each population of youth have many similarities and it would be impossible to discern a resident's referral source unless told specifically. I argue throughout this study that the categorization of residents by referral source means very little for understanding a young person's history, especially since many youth have had contact with multiple systems before being sent to residential placement. Clarice, for example, was technically an OCFS resident but had been living with her grandmother because of an ACS case against her mother. Another resident, Latoya, was an ACS resident but only because her mother had refused to take her home after Latoya was discharged from a state juvenile detention facility. The fact that residents encounter multiple agencies before arriving resonates with Goffman's (1961) concept of the "career" of the mentally ill person, as well as with Elaine Cumming's (1962) work on the paths by which patients reach a psychiatric hospital. Cumming's (1962) study of 55 psychiatric patients showed that these individuals had encountered an average of 9.5 "agents" (i.e., kin, friends, priests, doctors, police) on their path to the hospital and that not one had ended up in the hospital after encountering only one type of "agent" (e.g., only kin); the large majority of patients had seen at least three types. She writes, "we might speculate from these data that expulsion from society requires more than one judgment, or perhaps it requires a minimum division of labor" (Cumming 1962:240). Similarly, Edgewood residents' referral categories may represent only their latest encounter with government agencies.

Nonetheless, there are institutional functions to the categorization of youth by referral

source that continue to make these categories relevant. I review three such functions here in

regard to financial considerations, psychiatric diagnoses, and everyday assumptions about

resident behavior and clinical need on the campus.

Rates of Reimbursement

The most obvious reason that referral paths are relevant at Edgewood is because the

referral source is connected to the rate at which the campus is reimbursed for a resident's care.

The New York State Office of Child and Family Services sets maximum state aid rates that cover

all youth whose custody and/or guardianship have been transferred to an authorized agency.

These rates provide a per diem reimbursement for youth in care based on the "program

classification" of the agency. Program classifications indicate the type of population served by an

agency and are decided upon after agency staff complete a self-administered questionnaire based

on four scales: behavior, mental illness, developmental disabilities, and health problems.

Depending on the results of the questionnaire, an agency can be classified on a range from Class

1 ("severe rating on two or more scales") to Class 12 ("mild or none on all scales), or receive two

alternative classifications: "Group Emergency Program" or "Hard-to-Place Program" (See

Appendix C for a definition of "Hard-to-Place" under New York State Social Service Law).

Each class has a corresponding ratio of child care workers to children as shown in Table 4.

The staffing ratio and the program capacity determine the total number of staff needed by the

campus, which in turn, is correlated with the budget for child care and associated reimbursement

rates. The majority of Edgewood residents are served under a 1:5 staffing model while a smaller

group of CSE residents has been designated "Hard-to-Place" and are served with a 1:3 staffing

model. Accordingly, as of November 2010, the per diem reimbursement rate for "regular"

Table 4 New York State Program Classification for Institutions

Classification	Child Care Workers: Children	Criteria
1	1:3	Severe rating on two or more scales
2	1:5	Severe on the Mental Illness scale
3	1:5	Severe on the Behavior scale
4	1:5	Severe on the Developmental Disabilities scale
5	1:5	Severe on the Health scale
6	1:6	Moderate rating on two or more scales
7	1:8	Rating of just below severe on the Behavior scale and just below moderate on the Mental Illness scale
8	1:8	Moderate on the Mental Illness scale
9	1:8	Moderate on the Behavior scale
10	1:8	Moderate on the Developmental Disabilities scale
11	1:8	Moderate on the Health scale
12	1:8	Mild or None on all scales
Group Emergency	1:5	Emergency placements for children waiting placement in other facilities (cannot exceed 90 days at any one time)
Hard-to-Place	1:3	Special programs with enriched child care staffing for children with behavior and emotional disorders that are more severe than those served by regular programs with the highest classification.

Source: New York State Office of Children and Family Services 2006

residents was $202.14 per day while the reimbursement rate for the "Hard-to-Place" CSE

residents was $315.36 per day. What is more, the "Hard-to-Place" CSE residents received a

much higher Medicaid reimbursement rate compared to the "regular" residents—about $115 per

day compared to $25 per day.

The Clinical Portrait

In addition to influencing the amount of money that is attached to a resident, a resident's

referral source also determines, to some extent, what psychiatric diagnoses she will be labeled

with in her official case records. Table 5 provides data showing that among the 100 female

residents who lived at Edgewood between January and October 2010, 91 percent met criteria for

Table 5 Diagnoses for Female Population by Referral Source

DSM Diagnosis	OCFS (n=41)		ACS (n=45)		CSE (n=11)		DSS (n=3)		Total (N=100)	
	n	%	n	%	n	%	n	%	N	%
Any DSM Diagnosis	39	95.12	39	86.67	10	90.91	3	100.00	91	91.00
Any Disruptive Behavior Disorder	38	92.68	23	51.11	4	36.36	2	66.67	67	67.00
Conduct Disorder	30	73.17	11	24.44	2	18.18	0	0.00	43	43.00
Oppositional Defiant Disorder	3	7.32	10	22.22	2	18.18	1	33.33	16	16.00
Disruptive Behavior Disorder NOS	7	17.07	5	11.11	0	0.00	1	33.33	13	13.00
Attention Deficit Hyperactivity Disorder	5	12.20	10	22.22	5	45.45	0	0.00	20	20.00
Any Substance-Related Disorder	17	41.46	6	13.33	1	9.09	0	0.00	24	24.00
Alcohol Abuse	3	7.32	4	8.89	0	0.00	0	0.00	7	7.00
Cannabis Abuse	15	36.59	5	11.11	0	0.00	0	0.00	20	20.00
Polysubstance Abuse	0	0.00	0	0.00	1	9.09	0	0.00	1	1.00
Any Mood Disorder	13	31.71	25	55.56	6	54.55	1	33.33	45	45.00
Mood Disorder NOS	8	19.51	6	13.33	4	36.36	1	33.33	19	19.00
Depressive Disorder NOS	2	4.88	6	13.33	0	0.00	0	0.00	8	8.00
Dysthymic Disorder	1	2.44	2	4.44	0	0.00	0	0.00	3	3.00
Bipolar Disorder	2	4.88	12	26.67	3	27.27	0	0.00	17	17.00
Any Anxiety Disorder	3	7.32	9	20.00	1	9.09	1	33.33	14	14.00
Anxiety Disorder	0	0.00	1	2.22	1	9.09	0	0.00	2	2.00
Posttraumatic Stress Disorder	3	7.32	8	17.78	1	9.09	1	33.33	13	13.00
Adjustment Disorder	2	4.88	6	13.33	0	0.00	1	33.33	9	9.00

Note: Numbers for each diagnosis may sum to more than category totals since many residents have multiple diagnoses.

one or more psychiatric diagnoses. A few things are noteworthy about the data in this table. First, these diagnoses are listed in the table as they were given to me by the agency and therefore do not always use specific *DSM-IV-TR* (2000) terminology or codes. It is unclear, for example, whether "Anxiety Disorder" refers to Generalized Anxiety Disorder or Anxiety Disorder Not Otherwise Specified. Similarly, although Substance-Related Disorders were also always recorded by the agency as "abuse," it is unclear whether some of these diagnoses may have referred to "dependence." Second, the table does not include all psychiatric diagnoses for which these 100 residents met criteria. When all categories of disorder were considered, there were 206 diagnoses assigned to this group of girls (mean disorders per resident = 2.06, *SD* =1.24). The mean number of diagnoses for female residents did not differ significantly by referral source.[6] It should be noted that these numbers are likely an underestimate of all diagnoses for which this population meets criteria. These data were extracted from residents' admissions sheets, which contain only the diagnoses for which youth met criteria at the time of admission. However, many residents have had several mental health assessments prior to coming to Edgewood as well as assessments during their stay on the campus—assessments at which they met criteria for diagnoses that may be different from the ones listed here.

The table does show, however, that there are significant differences among resident categories for certain diagnoses. OCFS residents are significantly more likely than residents from all other referral sources to be diagnosed with any Disruptive Behavior Disorder (*p* < .01), Conduct Disorder (*p* < .01), any Substance-Related Disorder (*p* < .01), and Cannabis Abuse (*p* < .01). ACS residents are significantly more likely to be diagnosed with Bipolar Disorder (*p* < .05)

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6. A one-way analysis of variance test was conducted to compare the mean number of diagnoses across the four referral sources. There was no significant effect for referral source ($F(3, 96)$ = .12, *p* = .95).

and Adjustment Disorder ($p < .05$).[7] These differences are important to keep in mind for when I explain how staff perceive clinical need on the campus.

Perhaps the most important information to glean from these data, however, is what they do not reveal: the prevalence of specific diagnoses does not match up with what staff told me are the most common clinical problems for youth on the campus. Table 5 indicates that the three most common diagnoses for youth at Edgewood are Conduct Disorder (43 percent), Attention Deficit Hyperactivity Disorder (20 percent), and Cannabis Abuse (20 percent). In formal interviews with staff, however, I was told multiple times that the most common clinical problems were Posttraumatic Stress Disorder (PTSD) or Bipolar Disorder—diagnoses given to only 13 percent and 17 percent of female residents respectively. If Conduct Disorder was mentioned at all, it was dismissed immediately as being a "non-diagnosis" or a "manifestation of trauma."[8] At a certain level, then, there is a disconnect between what diagnoses are recorded officially in residents' case records and what staff perceive to be residents' underlying clinical problems.

Assumptions About Resident Behavior and Clinical Need

And yet, even if official case record data seem to have little practical impact on distinguishing resident categories on the campus, there exist deeply entrenched assumptions among staff at Edgewood about how a resident's behavior and clinical need are indicative of her referral source. These assumptions often differ depending on the staff member's position within

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7. Fisher's Exact Probability Tests were conducted for individual diagnoses to determine if there were any significant differences in diagnoses across the four referral sources. Fisher's Exact Probability Test is an alternative to Chi-Square procedures in scenarios where any observed cell frequencies are smaller than five.

8. The tendency for staff to reference "trauma" is interesting, particularly because it is not clear exactly what they refer to when they invoke the term. Young (1995:6) provides a compelling account of how "traumatic memory" was "*made* real" through its inclusion in the *DSM-III* as Posttraumatic Stress Disorder (PTSD) in 1980. Yet, staff do not always talk about PTSD specifically. Rather, they use the term "trauma" loosely and, in so doing, dilute its meaning. Anna Freud wrote about this problem even before PTSD was codified by the American Psychiatric Association; she feared that abuse of the term "trauma" would, "in the course of time, lead inevitably to a blurring of meaning and finally to the abandonment and loss of a valuable concept" (1967:235).

the organization—though not in clear-cut ways. The first set of assumptions staff make about

residents is related to whether and how a resident's referral source has an impact on her behavior

on the campus. On the one hand, several higher-ranking employees on the campus (not all of

whom work directly with youth or in cottages on a day-to-day basis) suggest that there are very

few differences between residents. Some indicate that this is because referral sources are in some

sense arbitrary: "Generally the kids just happen to get here through one door, but they could have

just as easily come in through either of the other doors, because they're generally part of all three

systems [ACS, OCFS or CSE], or their families are," one administration member told me

(Interview, October 28, 2010). Others admit that all youth at Edgewood face similar challenges

related to home life regardless of the referral source: "The more I see, the less I would say that

one group has less problems than another. It's interesting because I thought the CSE families

would have less problems, but that's not what we're really seeing" (Interview, November 10,

2010).

On the other hand, when speaking with staff whose job it is to work directly with youth

on a daily basis (Permanency Planners, Cottage Managers, Child Care Workers, Clinicians),[9] the

influence of referral sources comes across as being quite strong. Among these individuals, there

is wide agreement that ACS youth are "much harder" than youth from other referral sources.

Staff who spend the most time with youth (Cottage Staff and Permanency Planners) often told

me that ACS residents believe they are "untouchable" because there are few consequences for

their behavior. Whereas OCFS residents have the "sword of Damocles hanging over their heads"

because they can be "modified" (i.e., transferred to a more secure facility) for bad behavior or

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9. Staff roles will be described in depth in chapter 3. Permanency Planners are case managers who help youth find permanent home placements, coordinate aftercare services, attend court with residents and their families, and liaise with other agencies.

passed over for the Juvenile Justice Initiative, ACS residents do not live with such fear. A

longtime Child Care Worker described this attitude:

> Behavior between ACS and OCFS kids, it's different because the OCFS kids do have a
> discharge date, so as far as them planning on leaving, it has a lot to do with their behavior
> and whether they do get modified or stay out their term that they are scheduled to leave.
> The ACS kids, they're here, they don't have a discharge date, so their behavior is, I'll do
> what I want to do because I won't be held accountable, or because I can't get locked up.
> It's a big thing on the campus with that. They believe they're untouchables. They believe
> that nothing can happen as far as being held accountable if their behavior is out of
> control. [Interview, November 4, 2010]

While it would be unfair to say that there are no consequences for the behavior of ACS

residents—daily privileges or home visits can be suspended, for example—it is true that ACS

residents are at the end of the road in terms of placement options, having already been sent to the

most structured type of foster placement available. It is understandable, then, that many staff

believe residents leverage this reality. That the residents themselves also endorse such

distinctions between ACS and OCFS residents adds further support for these reflections.

The insistence that ACS youth are "harder" than OCFS youth resonates with another

assumption about residents at Edgewood: that ACS residents have more serious clinical needs

than other residents. Interestingly, this was a view espoused even by staff who told me that there

were no differences between residents and that referral source was somewhat arbitrary. A

clinician on the campus went to great lengths to describe to me the "very disordered

background" from which most ACS youth come: these are youth who have "fallen through a

whole bunch of foster homes," and arrive "totally traumatized, [having experienced] multiple

losses, feeling abandoned, feeling terrible, [with] low self-esteem, unloved, [and] no attachment

to anyone they can think of." She contrasted this directly with OCFS youth, whom she described

"as much higher functioning" because "they have homes they've come from and are going back

to, they know when they're leaving, they actually have families" (Interview, November 3, 2010).

While I would argue that the clinician here overstates the differences between ACS and OCFS residents (many OCFS residents did not live with their birth parents and were returning to home environments where caretakers had a history of incarceration and substance abuse), the logic she expresses is notable because it reinforces the very distinctions made in the case record data on diagnosis—namely, that ACS youth are more likely to have a "real" diagnosis such as Bipolar Disorder whereas OCFS youth are more likely to be labeled with a behavior disorder that is considered a "non-diagnosis." Thus, even as Edgewood staff talk about the prevalence of trauma-related disorders, there is a sense that these disorders are reserved for ACS residents. What begins to emerge is a picture of ACS youth who are "harder" but more worthy of clinical intervention, and an image of OCFS youth who are seen as mere "behavior problems" and, therefore, in less need of clinical help.

As "ACS" and "OCFS" are reinforced as classifications with a distinct character, Ian Hacking's work becomes especially relevant. Hacking has long been concerned with the classification of people, how such classifications affect the people classified, and how the effects on the people result in behaviors that ultimately change the classifications themselves (Hacking 1994, 2002, 2004, 2007). Following Hacking's logic, I argue that "ACS residents" and "OCFS residents" might be thought of as "kinds of people" about whom certain regularities in behavior and diagnostic categories are associated. This may have both short-term and long-term effects. In the short term, as residents learn what characteristics are associated with each category, they may adapt to these characteristics and behave in a particular way. Take, for example, the ACS resident who senses less accountability for her behavior and therefore becomes more irreverent than before. Or the OCFS resident who has been told time and time again that she is self-destructive or a safety-risk and thus continues to act out in a fashion that is expected of her. It is

only within the world of Edgewood (and the state agencies to which it is tied) that these categories have meaning and yet within that world such categories are natural, everyday labels. In the long-term, even if these female youth shed their referral classifications upon discharge, they will continue to carry a psychiatric label that implies that something is organically (and permanently) wrong with them. Whether explicitly acknowledged or not by staff and residents, I argue that such labels shape how residents conceive of and redefine themselves as well as their place within Edgewood and their larger social world.[10]

Indeed, across multiple interactions with residents, there were numerous times when OCFS residents told me that ACS residents could "get away with anything" but that they were still glad they were OCFS "because at least you know, you know when you're coming out." Furthermore, residents spoke about ACS as being symbolic of having parents who didn't love you or didn't want you. It was not infrequent during verbal altercations to hear one resident (of any category) say to an ACS resident something like, "You don't have anywhere to go… Your mother don't love you." Although similar statements might just as readily apply to OCFS residents in theory, OCFS residents were rarely the recipients of such comments and those that were might be overheard reminding their peers that they were OCFS. Categories clearly remain relevant to Edgewood residents no matter how much overlap may exist between them.

LIVING IN "THE 'HOOD PART 2"

Having spent the first part of this chapter describing the various paths to Edgewood and the phenomena associated with those paths, I turn now to the campus itself and to how Edgewood is conceived of as a place to live and change. I begin by providing an overview of the

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10. The impact of psychiatric labels specifically will be taken up in chapters 4 and 5.

campus and its daily routines so that there is appropriate context from which to examine deviations from that routine and how such deviations impact perceptions of campus life.

In many ways, Edgewood is a physical and figurative retreat for its residents. Located on a bucolic campus with cottage-style housing, Edgewood is a long way from the impoverished urban neighborhoods from which most of its residents come—places like Brownsville, Brooklyn, or the Redfern Projects in Far Rockaway, Queens, where the majority of residents live in poverty and where violence and crime are part of the everyday landscape. Indeed, the facilities at Edgewood would be easy to confuse with those of an elite boarding school. A large, colonial brick building houses the administration. It is surrounded by 12 resident "cottages" that have either one or two floors and contain approximately 15 residents stratified by gender and age. Four of these cottages are for female residents while the remaining eight are for male residents. Other buildings include a health center, a family center with offices for clinical staff, a large recreational facility and a maintenance building. The newest buildings on the campus are the redesigned high school and middle school; these schools serve 200 day-students in grades K-12 with behavioral, emotional and learning disabilities in addition to the Edgewood residents.

Given that Edgewood's residential population is composed in part by "juvenile delinquents," it is important to highlight that the campus is a "non-secure" facility (as opposed to the "secure" or "limited secure"). As such, Edgewood does not have gates at the entrance to the campus, lacks the barbed wire that is often conjured up when one thinks of detention facilities, and has cottage doors that lock from the inside only (i.e., residents can walk out of the cottage and off campus at will). The features of an open campus make it a more benign place to live in many ways and, for OCFS youth who were in secure detention facilities prior to admission, it affords new levels of freedom. At the same time, living in a "non-secure" facility presents

challenges of its own in terms of supervision, which, in turn, change the atmosphere on the campus. These challenges and their effects will be described below.

Daily Rhythms

In many ways, daily life at Edgewood mirrors that of a small society or total institution (Caudill 1958; Goffman 1961). Residents at Edgewood conduct all aspects of their life in the same setting, their activities are tightly scheduled, and their daily plans are put in place to fulfill the aims of institution. Residents wake up at 6:00 a.m. each weekday so that they can take their mandatory showers, complete their assigned chores, and eat breakfast before they start the school day at 8:00 a.m. All residents in the cottage walk down to the school building together with a staff member and attend classes until 3:00 p.m. At that time, a staff member from the cottage goes directly to the cottage's homeroom in the school building to pick residents up and escort them back to the cottage.[11]

The afternoon begins when residents return to the cottage from school and participate in a "Group Call." Group Call is held to "process the day." Residents stand in a circle with their staff in the foyer of the cottage and residents go around one by one to describe how their day went. While most residents provide one-word answers in Group Call, responding to the question of "How was your day?" with answers like "Fine," "Great!" or "Bad," Group Call is also a time when residents and staff can confront residents for particular behaviors during the day. Residents might confront each other for something that occurred in school while staff might confront a resident for something that was written in the daily log-book that each cottage keeps to report events and incidents from the day. Often, this involves a staff member on the afternoon shift

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11. I did not spend time in the school during my fieldwork with the exception of when I picked residents up from their homerooms in the afternoon. The school's curriculum is based on the standard New York State curriculum but there is a big emphasis on "credit recovery" in the high school so that residents can "catch up" on lost time in school and work toward graduation.

(3:00 p.m. to 11:00 p.m.) asking the resident for an explanation about something written down by a staff member who was working the overnight shift the previous day (e.g., they didn't complete their chore, they wouldn't get out of bed, they had to be "redirected" too many times).[12] In certain cases, the resident may have to serve some type of accountability for her behavior such as staying inside her bedroom ("serving room restriction") or cottage ("having cottage") for the afternoon. Similarly, if a resident has a problem with a peer in the cottage, Group Call is a time when she can raise the problem (residents are also allowed to call a group call at any other point in the day if they want to address a peer). Group Calls are also held at transition points in the day such as when residents are preparing to eat dinner or attend an activity. During these transitional Group Calls, residents "set expectations" for the particular activity. Residents about to sit down to dinner, for example, might say, "eat quietly" or "wash your dishes."

Once the afterschool Group Call is "dismissed," residents settle into a variety of afternoon activities. On two to three days of the week, a type of group therapy called Guided Group Interaction is scheduled (Guided Group Interaction will be the subject of chapters 4 and 5 so will not be described here). On other afternoons, however, residents may participate in afterschool tutoring, attend job readiness training or work at campus jobs (such as cleaning campus facilities or helping out in an office), go to a positive peer training on the campus, visit to the art room, or attend a sports practice. What residents can participate in is dependent not only on their "level" within the cottage (described shortly) but also on their cottage staff, who have different attitudes about how much residents should be out of the cottage. In Thayer Cottage, for

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12. There are two main shifts for child care workers: 3:00 p.m. to 11:00 p.m. and 11:00 p.m. to 7:00 a.m. During the hours of the school day, no child care workers are in the cottage unless a resident has been suspended from school for the day. In that case, one child care worker will supervise the resident in the cottage.

example, all residents are encouraged to get campus jobs as soon as they are able to do so because the staff want them out of the cottage and involved in activities. In Hamilton Cottage, however, residents are kept inside the cottage until they have a proven track record of good behavior and have earned the trust of cottage staff. Residents also differ in their own willingness to participate in activities outside the cottage. While some residents do everything they can to get out of the cottage, others seem to prefer staying in the cottage each afternoon, talking with friends, playing cards, or reading. Residents are occasionally allowed to use the computers in the cottage but the appeal can be limited since they are not allowed to go onto social networking sites like Facebook and MySpace (many residents have accounts that they access at school).

In the evenings, residents are expected to return to the cottage for dinner (usually around 5:30 p.m.) and then complete their chores again and take their evening showers. On some evenings after dinner, the cottage will have an activity. On most nights, however, post-dinner is a time when staff members try to settle down the cottage and get residents ready for bed. Girls are allowed to read or write in their journals or talk quietly with their roommates. Residents also will be allowed to watch television on occasion. By 9:00 p.m. residents are expected to be in their bedrooms with their doors closed.

Similar daily schedules are in effect Monday through Friday and vary only on the weekends. On Friday, residents who have home visiting privileges leave the campus after school. A campus van drives residents to the closest mass transit station, at which point they are given metro cards and expected to return home on their own (they must return to the same place on Sunday with enough time be driven back to the campus by 7:00 p.m.). For residents who remain on campus, weekends are a time of "down time" where residents can watch television, spend time in the gym, have family members visit, or work campus jobs. Cottage Managers also plan

off-campus trips such as going to the movies or the mall, with staff transporting residents in campus vans.

Regardless of the type of activity they are engaged in, residents are expected to be "in program" at all times. That is, they are supposed to be in the appropriate place, at the appropriate time, and with the appropriate permission. Residents who want to leave the cottage for any activity must have a written pass signed by a staff member that indicates where they are going and the time they left the cottage. They are also expected to return to the cottage as soon as the activity has concluded. Residents who do not follow these programs are considered "out of program" or, as residents and staff say more frequently, "OP."

The Force Field

The daily schedules of individual Edgewood youth are very much determined by the campus's Force Field[13] which rank residents as "Gold," "Silver," or "Bronze." For the first three months of my fieldwork, the Force Field consisted of "Positive," "Neutral," or "Negative" rankings and was related exclusively to weekly ratings of a resident's behavior by her cottage staff. The administration then changed the labels of the Force Field, however, and told residents that their school performance would be considered in their rating as would their progress toward discharge (e.g., having positive home visits or being willing to explore alternative resources for discharge if one's former living arrangements/guardians are not an option). The residents in Hamilton Cottage found this change particularly amusing because they were convinced that it was being done merely to avoid labeling someone as "negative." The irony of changing the

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13. It was not until after leaving the field that I discovered sociologist Kurt Lewin's (1951) work on force field analysis, a model of change that describes any current level of performance as a state of equilibrium between forces that encourage change and those that discourage it. Force field analysis enables people to organize information in terms of its relevance for change. Though I have not confirmed whether Lewin's model is the inspiration for Edgewood's force field, it certainly makes sense that it would be.

Force Field terminology to avoid pejorative terminology was not lost on a group of girls who have been told they are "negative" consistently throughout their lives. Nevertheless, Force Field ratings determine a resident's privileges on campus and in the cottage and are also linked to weekly allowances given by the campus. Residents on "Bronze," for example, are often prohibited from working their campus jobs and are not allowed to go on off-campus trips. Meanwhile, residents on "Gold" are allowed to walk the campus without a staff escort, may be allowed to stay up later at night, and earn respect from staff and some peers. Being a "positive peer" is the "Gold" standard on the campus.[14]

On an institutional level, the Force Field matters because it is the primary mechanism through which residents are persuaded to follow the rules of the campus and the daily program. Goffman devotes part of his work in *Asylums* to describing the privilege systems found in total institutions (and the associated withdrawal of privileges as a form of punishment) and to the way these systems obtain cooperation from people who often have cause to be uncooperative (1961:52). Similarly, Rhode's more recent work in a maximum security prison suggests that prisons maintain their order primarily through an infraction system that aligns self-interest with institutional rules. Rhodes writes, "the logic of the infraction system is intended to engage the rationality of the inmate. It posits that eventually—if staff hold their ground and refuse to deviate from supplying consequences—the prisoner will make a connection between what he does and what happens to him" (2004:76-77). A similar logic might be said to operate at Edgewood, where administrators and staff stress routine and consistency in their interactions with residents; their hope is that the privileges associated with being on "Gold"—and the lack of privileges associated with being on "Bronze"—can be a meaningful motivator for following rules.

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14. The Force Field model also resonates with the behavior modification technique known as "token economy," a reinforcement system in which patients who perform specific behaviors satisfactorily are rewarded with tokens, which can later be exchanged for privileges (see Bailey et al. 2011 for a recent example in a residential care facility).

Deviations and Secondary Adjustments

Of course, it would be naïve to assume that all Edgewood residents follow the rules and expectations for behavior all of the time. On an open campus, where residents receive home passes regularly, and where additional day students come to and from school each day, Edgewood is never completely isolated from the broader external world. In fact, given New York State's renewed emphasis on maintaining a young person's connection to her community while she is in residential treatment, the ability to cut off any resident from negative outside influences is minimal. Edgewood thus sees its fair share of drug use, sex, and gang activity on the campus, as well as a high rate of AWOLing.[15] Such "illicit" activities are what Goffman called "secondary adjustments"—"any habitual arrangement by which a member of an organization employs unauthorized means, or obtains unauthorized ends, or both, thus getting around the organization's assumptions as to what he should do and get and hence what he should be" (1961:189). In the case of Edgewood residents, obtaining and using drugs, or engaging in sex or gang activity, is usually done by going "out of program" or AWOLing and flouting the campus rules about where residents should be at any given time and under whose supervision.

The extent to which Edgewood residents break campus rules and participate in these sorts of activities is surely related in part to normal adolescent development and its concomitants of experimentation and boundary-testing. So, too, are these activities linked to boredom on the campus and to the monotony of living in a relatively confined space for months on end while being observed constantly for rule-breaking. Finally, at least as it is relates to drug use, some

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15. AWOLing—or leaving the Edgewood campus without permission—is more common among ACS residents than OCFS residents since OCFS residents can be "modified" to a more secure facility if they AWOL. I did a rough calculation of AWOLing by residents in Hamilton and Thayer during the 11 months of my fieldwork by looking at the census I recorded for each day I was on the campus. My calculations show that 23 of the 62 residents (37.1 percent) in these cottages during my research AWOLed. These 23 residents accounted for 44 instances of AWOLing from the campus. The breakdown by referral source: 15 ACS residents (65.2 percent); 5 OCFS residents (21.7 percent), 2 CSE residents (8.7 percent); and 1 DSS resident (4.4 percent). This is likely an underestimate of AWOLs because I was not on campus every day.

residents clearly smoke marijuana and drink alcohol because of growing addictions to these substances. But it is also true that some residents do not buy into the Force Field system or value the privileges and punishments that come alongside it. As Rhodes explains in relation to prisoners, the cause and effect relationship between an act and its sanction is not straightforward; "prisoners describe making choices in which an infraction is simply the lesser of two evils" (2004:78). Rhodes gives the example of a man who indicates that he will continue fighting other inmates even if it means going to the "control unit" because it will bolster his reputation within the prison. Similar examples can be found at Edgewood. There are residents who join gangs because they do not want to risk being "jumped" (i.e., beaten up) in their own cottage, and there are residents who go out of program because they would rather get in trouble than participate in group therapy. Oftentimes, the threat of losing privileges or serving room and cottage restriction is not enough to keep residents from engaging in these activities, and the modicum of control that residents maintain over their lives while engaging in them ensures that such activities will continue. Viewed from the perspective of personal agency, such actions speak to the ability for Edgewood residents to read their environment and act rationally within it. As Rhodes writes, "these are rational decisions based on their understanding of the intersecting and contradictory rules that constrain their lives" (2004:78). Although staff on the campus certainly do not condone these episodes of rule-breaking, such agentive actions may ironically be reinforced by the very insistence that residents take responsibility for their actions. I explore this theme of personal responsibility below and in later chapters.

Perceptions of Campus Life

What is the impact of living in a residential treatment center where the outside world cannot be kept at bay? How does it influence how residents and staff think about Edgewood as a

place to live? And what does that mean in turn for conceptualizing the expectations placed on

residents who live there? Throughout my fieldwork, I heard Edgewood described by female

residents as "the projects," "the 'Hood," and "the 'Hood part 2." It is important to realize that

these descriptions were intended neither to be ironic nor derogatory. Rather, they pointed to the

fact that many residents see Edgewood as a minor variation on the chaotic outside world rather

than as a place of respite and treatment. That is, Edgewood residents must reconstitute "home"

within the space of a residential treatment center even though the "home" they build is never

entirely removed from their communities of origin. Furthermore, the transitions residents make

in and out of the campus on home passes mean that their lives are never fully eclipsed by the

institution. Experiencing a persistent tension between institutional life and life on the "outside,"

Edgewood residents make sense of an environment that is seemingly incompatible with their

former lives by bringing the outside in.

If, for residents, "the 'Hood part 2" signifies the enduring link between Edgewood and

home, it also represents the very set of conditions that Edgewood staff are trying to keep at bay

on the campus. For all of the potential differences that exist among residents at Edgewood based

on their referral source—and for all of the times I was told about the important distinctions

between ACS residents and OCFS residents—there is a lingering sense on the part of many staff

that youth on the campus are "tougher" today than in years past. This increased toughness is

attributed to multiple sources. Some staff cite economic changes that have impacted social

welfare policies and led to decreased hope among youth:

> I think because there have been a number of economic changes over time, what I am
> seeing is that for many of the young people, and their families, there have been increasing
> gaps in the resources that are available to them so that they are having more and more
> problems. There has been a decrease in those institutions they would need, decrease in
> services across the board, educational services and medical services, in particular mental
> health services. So that I think their problems have grown deeper and also I would say

their own sense of hope for themselves and their future has changed, that they have less hope, they have less belief that things are going to be better for them. They're a little bit more difficult to reach I think, and I also think that might be part of the reason we're seeing more use of marijuana and other drugs and so forth because they're less hopeful that they have a real future. [Interview, November 10, 2010]

Others blame a fraying moral fabric in society as a whole:

I think society as a whole, morality is going down. As society moves, the campus is moving in that direction too. I'm not saying, drugs have always been around here, gangs have always been around, but it's been more on the hush hush, underground low, nobody really heard of it or done it and it was more discrete, more discretion with it. Now it's more open and I think the youth of today, today meaning 2010 today, they have less fear of anything. [Interview, October 28, 2010]

It is difficult to establish if the campus population has changed markedly over time or, more probably, if what staff discuss reflects a certain nostalgia for an idealized past. But whereas residents describe Edgewood as a place where outside influences creep in to create a treatment environment that more closely mirrors their home communities (however "broken"), staff articulate a sense that the campus feels "unstable" and "less safe" than they would like. What feels "less safe" to staff, is "home" for residents.

Even as "the 'Hood part 2" can be read in multiple ways by different actors, it is also uniformly identified as a provisional place of residence. In turn, this sense of impermanence transforms what residents and staff understand as the purpose of the institution. In my interviews and daily observations, residents spoke about their priorities at Edgewood in a way that conveyed to me their sense of the campus as a place of temporary confinement rather than one of rehabilitation. "I just came here to do what I gotta do" one resident told me candidly (Interview, October 14, 2010). This phrase—"do what you gotta do"—was omnipresent during my research. Whether said in casual conversation or in interviews with me, as a warning or as a piece of advice from peers, residents used this phrase daily as a way of describing what their focus should be while at Edgewood. Staff too—particularly Cottage Staff and Permanency Planners—

counseled residents with the same terminology. The meaning is specific: do what is necessary to ensure an on-time or early discharge. Said another way, "do what you gotta do," means "*don't do*" anything that will delay your discharge (*read*: go out of program or AWOL, use drugs, engage in gang activity, etc).

That staff, too, adopt the attitude of "do what you gotta do" is emblematic of the real constraints that the campus faces in sustaining a treatment environment in the current economic and political climate. The move to keep youth out of residential treatment—on the grounds that it is both cost effective and in the best interests of a child to do so—means that there is real pressure to shorten lengths of stay at places like Edgewood. This can be difficult in the case of ACS youth, who often are only at Edgewood because no alternative and viable community-based placement can be found. It is presumably easier in the case of OCFS youth, since they are serving a specific disposition and are assumed to have intact families to which they are returning. And yet, an interesting reversal occurs in terms of treatment. Insofar as it is harder to find placements for ACS youth, it is also easier to ensure that they remain at Edgewood for a length of time that enables sustained engagement in clinical, educational and other services; there is some "wiggle room," so to speak. Meanwhile, because OCFS youth have a firm discharge date, there is little that can be done to change the terms of their treatment at Edgewood. The fact that most OCFS youth become eligible for JJI while at Edgewood also means that original dispositions of 12-18 months are now reduced to 6 months. Understandably, many staff feel that reducing lengths of stay leaves them with less time to "impact" youth.

The mantra of "do what you gotta do" is suggestive of two additional points about the relationship between custody and treatment at Edgewood. First, it is worth revisiting the question posed by Rhodes about "whether what one is *made* to do can—or should—become what one

chooses to do" (2004:63). A "do what you gotta do" attitude implies that on some level, living at

Edgewood is part performance and strategy. Residents must convince staff members and

administrators that they have changed and that they are ready for discharge. But this does not

necessarily mean that these changes will last. Chandi, an OCFS resident in Thayer Cottage who

was nearing her discharge date half way through my fieldwork, exemplifies this well. Chandi did

everything that was asked of her while on the campus. She followed rules and excelled in school,

she was rarely out of program, she worked a campus job dutifully, and she participated in all

required cottage activities. For this reason, she was given quite a bit of latitude by staff in the

cottage, who felt they could rely on her to follow the campus program and that they did not have

to watch her as closely. Meanwhile, staff knew that Chandi had maintained her affiliation with

the Latin Kings gang while on the campus and that she was likely to continue this activity upon

leaving. One administrator described Chandi's transformation at Edgewood as "superficial,"

reflecting, "The reality is that she hasn't internalized anything at all." The fact that Chandi

succeeded in working within the "do what you gotta do" framework, however, meant that staff

were willing to overlook the fact that she had not internalized change; Chandi's gang activity

could be ignored because she operated within the boundaries of the Edgewood program.[16]

Second, I argue that as the "do what you gotta do" attitude is reinforced from both above

and below, the locus of responsibility for personal transformation is shifted from the institution

itself to individual youth. Just as Rebecca Lester (2009) found that staff at an eating disorder

treatment center invoked specific ways of talking about patients that justified an ethical course of

treatment in the otherwise ethically ambiguous situation of managed health care, so too does "do

what you gotta do" provide for a clear path of action in an environment with few desirable

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16. It is worth noting that some staff feel conflicted about telling residents to leave gangs. Although many of the
gangs that Edgewood residents are part of (e.g., Latin Kings, Crips, Bloods) are notoriously violent, it is also true
that gangs have long provided youth with a community as well as needed protection in dangerous neighborhoods.

alternatives. In a place where there is a mandate for treatment but scarce resources of time and money to provide for it, the responsibility for change is thus necessarily placed on the individual. The prescription to "do what *you* gotta do" reminds residents that how they behave is a choice that is theirs to make. So too does it express that at some basic level personal transformation— and the ability to leave Edgewood—is within their own power.

CONCLUSION

The assessment of resident classifications and the description of the campus and its program described in this chapter were intended first to orient the reader to the youth who live at Edgewood and to the daily schedules that these youth follow. It is clear that youth travel to Edgewood on a variety of paths and that these paths are relevant on an institutional level in terms of the rate at which Edgewood is reimbursed for care, how residents' psychiatric disorders are documented, and what types of services residents are considered to need. Once on the campus, residents are oriented to a schedule that is designed to maintain an orderly environment where rules are followed and youth are supervised. The Force Field system is designed with the intention that residents will learn to connect their behavior with consequences and to internalize the link between good behavior and rewards. As we will see in chapter 4, a similar connection is assumed in the positive peer culture model that is the basis for Edgewood's group therapy.

Official classifications and programs may only go so far, however. This chapter also has demonstrated that there are significant departures from the way things seem to operate at first blush on Edgewood. Resident classifications, for example, may be described as overlapping but so too are they taken to be signifiers of residents and their backgrounds; there is a surprising disconnect between official rhetoric and the reality of how classifications matter on the ground level. The result is that "ACS" and "OCFS" have become over-determined categories, associated

with specific attributes and ways of being in the world. I have argued that this fact necessarily influences youth and their self-perception; who they are at Edgewood and how people respond to them are defined first and foremost by their referral category.

That the campus program also deviates from what might be intended is surely inevitable at a place like Edgewood despite the hard work on the part of staff to maintain consistency. Residents find ways to participate in some of the same prohibited activities that they engaged in before coming to Edgewood and the result is that they tend to characterize their campus as a variation on their former lives rather than a significant departure from them; for these youth, Edgewood is "the 'Hood – part 2." I have suggested that one of the consequences of this orientation is to transform Edgewood in the minds of residents from a place of rehabilitation to a place that is to be endured. Such attitudes are reinforced by staff members, who feel their ability to make an impact is limited, and by state officials, who insist on shortening lengths of stay (and thus time for treatment). In turn, Edgewood residents come to understand personal change as something that must be accomplished individually—a burden to bear on one's own—even if that change is temporary and strategically linked to discharge.

In the following chapters, I look more closely at how life unfolds in "the 'Hood part 2." I do this first by examining the staff world at Edgewood and the ways in which staff members both experience and adapt to the demands of an enormously stressful environment. I then turn to group therapy at Edgewood as a key site for examining the ways in which female residents are remade within the space of residential treatment. This will allow for a more vivid understanding of the expectations placed on Edgewood residents in terms of personal change and of the creative ways that residents manage such expectations.

CHAPTER 3
WORKING AT EDGEWOOD

This chapter addresses the staff world at Edgewood and to how working relationships play out in "the 'Hood part 2." Staff at Edgewood work together under an impossible bind: they are expected to treat residents adequately and return them quickly to their home communities. As staff work under these twin demands, it does not always mean that they are united in their goals or share a common understanding of how the campus operates. In this chapter, I outline three central areas of employment on the campus—Group Living, Permanency Planning, and Clinical Services—in order to demonstrate how working relationships are reflective of a staffing structure that divides employees along the lines of custody and treatment functions. I suggest that how staff are positioned along the custody/treatment divide impacts their perception of their work as well as their understanding of how Edgewood residents should be treated, although in ways that are not entirely clear cut. This can lead to shifting alliances and discord over whose responsibility it is to achieve certain ends.

This chapter is also an examination of how staff overcome some of the divisions among them to get work done and maintain solidarity in a difficult working environment. I look at "Rounds"—biweekly meetings where staff come together to review residents' case records—as a key site for collaboration and demonstrations of support. On the one hand, I illustrate how Rounds are integral to the gathering of information about residents that can be put toward the goal of discharge; staff work together in creative ways to meet the reporting demands required of them by the agency, the city, and the state. On the other hand, I demonstrate how Rounds serve as an important outlet for staff working under conditions of enormous stress. By examining the role humor plays in these meetings—the offhand comments, the nicknaming, the sense of the incongruous—it becomes clear that Rounds serve an additional purpose for people who work at

Edgewood: to bolster morale in a place where the difficulty of doing good is mutually (if tacitly) acknowledged.

STAFFING STRUCTURE

In order to understand how working relationships develop at Edgewood, it is necessary to provide an overview of the staffing structure on the campus and to clarify certain job descriptions. Figure 2 shows an organization chart for Edgewood.

Figure 2 Organizational Chart for the Edgewood Campus[1]
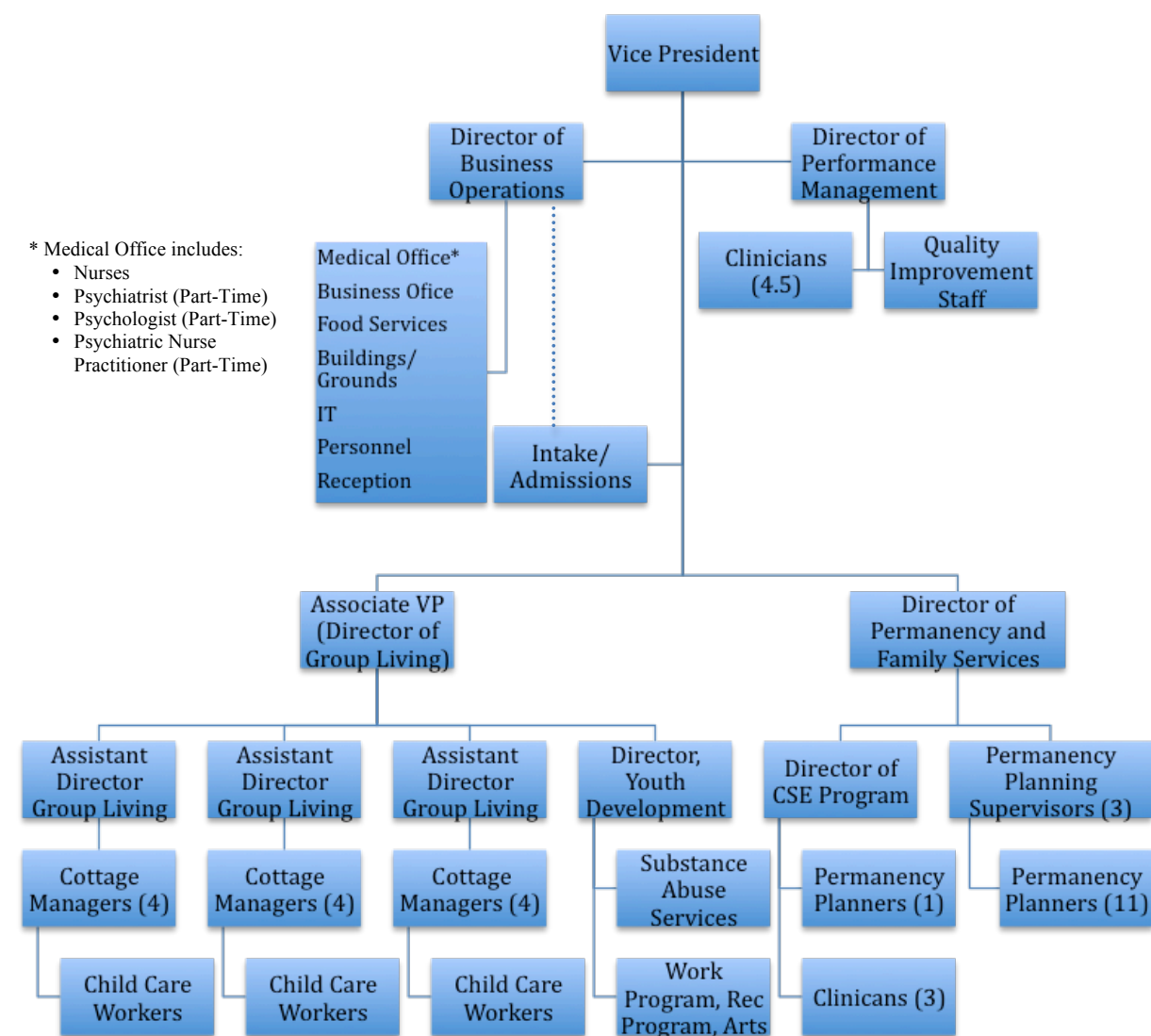
1. This is not a comprehensive organization chart. Certain areas have been left out that might further identify the organization and that are not directly relevant to the material in this chapter.

The campus is headed by a Vice President who lives on the campus and reports to the President and Chief Executive Officer of the larger agency of which Edgewood is a part. Below, I focus on staff roles within three key areas: Group Living, Permanency Planning, and Clinical Services.

Group Living/Cottage Staff

Staff within the area of Group Living are most directly involved in the day-to-day lives of Edgewood residents. All cottages on the campus have one Cottage Manager, one Senior Child Care Worker, and multiple Child Care Workers (there are 85 total Child Care Workers on staff). The allocation of Child Care Workers to each cottage depends on the number and type of residents in the cottage. Cottage Managers have the highest level of daily responsibility and the most supervisory duties. They must have a high school diploma or a General Equivalency Degree (GED), but a bachelor's degree is preferred and two years of supervisory experience in child welfare is necessary. Ms. Austin and Ms. Williams, Cottage Managers of Hamilton and Thayer Cottages respectively, both have bachelor's degrees and had been in the field of child welfare for several years prior to coming to Edgewood.

Working under Cottage Managers, each cottage has one Senior Child Care Worker and several Child Care Workers "responsible for providing supervision and ensuring the health, safety and well-being of each child in their care."[2] Senior Child Care Workers are required to have a high school diploma or GED, two years of experience, and state certification. They are responsible for supervising Child Care Workers and for undertaking compliance-related duties such as establishing rules, utilizing behavior management techniques, and filing incident reports. By contrast, Child Care Workers must have a high school diploma or GED; state certification

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2. The information on job qualifications in this section is taken from data in my field notes as well as from a job posting publicly available on the Internet. I have not provided the details of this source because it would compromise the anonymity of the institution.

and experience are "preferred." The focus of their job duties is more about engaging residents than ensuring compliance with protocol. In theory and according to the official job description, a Child Care Worker "serves as a role model for residents in the areas of ethics, morals, appearance and lifestyle principles… [and] provides guidance and direction to residents in a manner that develops and nurtures socially appropriate values." In practice, administrators emphasize wanting to hire staff who "are not afraid of the kids"(Interview, August 3, 2007). Ms. Williams, the Cottage Manager of Thayer, described what she was looking for:

> You can kind of look, I can kind of size up somebody when they walk through the door whether this person is going to stay or not… you know what's needed in a cottage. You don't need somebody that is good with arts and crafts. I need somebody that is good if you see a child escalating in their behavior, are you going to be good at trying to calm that child down or are you going to add to that child being excited. Stuff like that. Are you able to move quickly when you need to move quickly? [Interview, November 3, 2010]

Regardless of the official job description then, it is clear that a premium is put on finding individuals who will engage residents directly and diffuse problems quickly; Child Care Workers have to be willing to get their hands dirty, so to speak.

Apart from title and level of responsibility, primary distinctions between Cottage Managers and Child Care staff are salary and union membership. Cottage Managers earn $43,000 annually but are neither eligible for overtime nor in a unionized position. Meanwhile, the starting salary for Child Care Workers is $13.55 per hour (resulting in an annual salary of approximately $27,000 for a 40-hour work week). Child Care Workers, however, are entitled to overtime and are also union members who are afforded accordant benefits and protection. In conversations with Child Care Workers, I was told that health care benefits offered to them are more comprehensive than those given to people in "management" (i.e., Cottage Managers). Despite these added benefits, it is widely acknowledged—even among administrators on the

campus—that it is generally not possible to make a living working only as a Child Care Worker; most Child Care Workers have second jobs in addition to their full-time positions at Edgewood. As the Director of Group Living told me during my fieldwork in 2007, "In the scheme of life, to be a Child Care Worker, you can't pay your rent unless you pick up a lot of overtime or you have two jobs. A lot of my staff have two jobs because you can't, you can't live out there like that" (Interview, August 3, 2007). Several Child Care Workers I knew had full-time jobs at the Edgewood school during school hours (8:00 a.m. to 3:00 p.m.) and would then work the afternoon shift in the cottage (3:00 p.m. to 11:00 p.m.)

Permanency Planning

Permanency Planners do not work directly in cottages but interact with residents on a daily basis and have ongoing contact with residents' families. As case managers, they are responsible for helping Edgewood youth find permanent living situations and for coordinating services for residents once they are discharged from the campus. This job requires Permanency Planners to make regular field visits to residents' homes and to liaise with the state and city agencies overseeing residents' care. Often, this means attending court hearings with residents and their parents to provide updates to the judge on the resident's case or, in the case of juvenile justice youth, to ensure youth attend follow-up court dates. In this sense, Permanency Planners are oriented to a resident's discharge date from the moment the resident arrives and work is organized around ensuring an orderly transition out of residential care. A Permanency Planner described this orientation to me:

> I keep in contact with the children, the parents, make sure their service plan is in place, and we work toward getting them toward their goals. For example, if they have a goal of return to parent, we put services in place to make sure when they do actually get discharged to their parents, that everything will move smoothly. [Interview, November 2, 2010]

Most residents, and many staff, on campus refer to Permanency Planners as social workers because they perceive the job responsibilities as being in line with those of a traditional social worker who brokers services. Some administrators frown upon this practice, however, because many Permanency Planners are not licensed social workers (the job requires only a bachelor's degree) and because the administration wants to emphasize the goal of permanency for all youth. Permanency Planners earn $36,000 annually and are not unionized.

Clinical Services

Those with the title of "Clinician" at Edgewood deliver individual and group therapy to the residents of one or two cottages on the campus. As the organization chart shows, clinicians are dispersed in different areas of the organization, depending on what residents they see (some clinicians report to the Director of Performance Management; others report to the CSE Program Director). The title itself is also broad, since clinicians have varying levels of education and experience. The clinician responsible for Hamilton Cottage, for example, is a woman who has a Ph.D. in Psychology and has worked at Edgewood for 16 years. She was trained first in psychodynamic approaches and, more recently, in cognitive behavioral therapy. Another clinician, who worked in Thayer Cottage for part of my fieldwork, is a Licensed Clinical Social Worker (LCSW) and holds a lecturer position at a graduate school of social work. Finally, other clinicians have master's degrees in social work; some are Licensed Master Social Workers (LMSW) while others are LCSWs.[3] Because of these differences in training and experience, the salary range for clinicians is wide despite the fact that all clinicians have similar responsibilities.

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3. The degree titles are related to level of education and experience. In New York State, a LMSW has earned a Masters in Social Work (MSW) and has passed a national licensing exam. A LCSW has already met the requirements of an LMSW, has completed coursework on clinical content such as diagnosis and treatment, has completed at least three years of post-degree supervised experience, and has passed a clinical licensing exam. See New York State Education Law, Article 154.

In addition to the clinicians who work full-time at Edgewood, Edgewood employs a psychiatrist, a psychologist, and a psychiatric nurse practitioner, all of whom work part-time. These individuals are responsible for conducting evaluations of residents and, in the case of the psychiatrist and the psychiatric nurse practitioner, for prescribing and monitoring psychotropic medications. While these positions are integral to the delivery of clinical services at Edgewood, the fact that they work only part-time and that their offices are located in the Health Center (away from the offices of Clinicians and Permanency Planners) means they are not well integrated into the daily life of the campus. Many youth at Edgewood will only meet these individuals when a formal evaluation is required before discharge.[4]

It is relevant to note that the arrangement of Clinical Services at Edgewood was in a state of flux during my research. When I arrived at Edgewood in January 2010, there was a Clinical Department led by a Director and an Assistant Director who oversaw clinicians working directly with youth in cottages. By June 2010, both of these positions had been eliminated, and clinicians were reporting directly to the Director of Performance Management, who had maintained oversight of the Clinical Department during the previous 18 months. This individual left the organization in May 2011 to pursue another opportunity; it is unclear to whom clinicians are reporting at the time of writing. The impact of this reorganization on working relationships will be described later in this chapter.

THE CUSTODY/TREATMENT DIVIDE

Having outlined the staffing structure at Edgewood and described three key areas of work, I turn now to examine how working relationships are reflective of that structure. Lorna Rhodes' (2004) work provides a useful model for thinking about how staff at Edgewood are, to

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4. Residents at Edgewood do not automatically receive psychiatric and/or psychological evaluations upon arrival to the campus. However, they do receive an initial psychosocial examination completed by their clinician.

some extent, divided along the lines of custody and treatment depending on their job duties. Comparing prison guards to mental health workers in a maximum security prison, Rhodes suggests that in addition to involving qualitatively different types of work, "custody and treatment entail inherently contradictory structural positions" and "the friction between them results from their differential possession of power and knowledge" (2004:132-133). If custodial staff do their work by exerting power over prisoners, treatment workers stand on the knowledge they have about those prisoners (in this case, prisoners' psychiatric diagnoses). These competing perspectives lead to alternative understandings of prisoners' actions even as they are united in mutual dependence within the prison environment.

Edgewood staff are not divided as neatly as the prison staff that Rhodes describes (and Rhodes admits that cross-alignments occur along the custody/treatment divide) but her work remains relevant to the extent that there is a significant divide at Edgewood between people who work in the cottages and are with residents constantly and those who work in offices and interact with residents at scheduled intervals. I illuminate this divide here by examining how staff within and outside the cottage perceive their position and their work within the Edgewood organization.

On the Side of Custody

As in many institutional environments (Rhodes 1991, 2004), those who earn the lowest pay at Edgewood—Child Care Workers—have the most intense and ongoing contact with residents. On the one hand, this gives child care workers a certain amount of power. Despite being at the bottom of a staffing hierarchy, Child Care Workers often have the closest relationships with residents and have influence over residents where other staff members do not. On the other hand, by virtue of their job title as well as their physical location in the cottage, Child Care Workers are often excluded from key conversations about residents and campus life.

Whereas Permanency Planners, Clinicians, and Cottage Managers have internal meetings weekly, Child Care Workers meet only once a month with the staff in their particular cottage (Cottage Manager and other Child Care Workers). Furthermore, Child Care Workers are not always included in (and in my experience, were generally excluded from) "Rounds," where staff across departments meet twice a month to update each other on all residents within a cottage, or in "Strategic Case Reviews," where staff discuss a single resident's case as a team for two hours. One Senior Child Care Worker told me that part of the reason Child Care Workers were excluded from meetings was due to constraints imposed by union membership. "We used to have senior workers' meetings with managers," she noted. "But after a while they realized there was an issue there because it's not permitted for non-unionized workers to have meetings with unionized workers. Managers and unionized workers bump heads. We're not allowed to do that, so they cut that out about a year ago" (Interview, November 4, 2010). Although no other staff at Edgewood raised this particular concern, the consequences of excluding Child Care Workers from key meetings remain. The people who spend the most time with residents at Edgewood— and are the most knowledgeable about residents' day-to-day behavior—are often the least informed about residents' histories, mental health problems, or permanency plans.

Cottage Managers also spoke to me about feeling they were excluded from important communication regarding residents as well as decision-making on the campus. One Cottage Manager, for example, explained to me that Cottage Managers are not involved in interviewing Child Care Workers even though Child Care Workers will report to them once hired. "We are not incorporated in any decision-making. With staff you hire, I feel that we should be in on interviewing staff… you just get somebody, you get a call saying somebody new is starting tomorrow. You have no input on, not even staff that is coming to your particular cottage"

(Interview, November 3, 2010). Perhaps not surprisingly, being left out of this decision-making was tied directly to the perception that cottage staff are accorded very little respect from other leaders on the campus. As the same Cottage Manager told me when describing how residents are sometimes moved from one cottage to another with little notice or justification, "Along with respect comes the communication that is attached to it. As you can see, kids get moved around, nobody even tells you, so where is the respect? They should let us know you're sending somebody over here. It just makes no sense" (Interview, November 3, 2010). Comments from cottage staff about not being adequately informed—and the link made to receiving little respect—appear frequently in my field notes and express palpable resentment toward staff in higher positions.

On a broader level, Cottage Managers and Child Care Workers speak about respect as being linked to what they suggest is an impossible demand: to do more work with fewer staff. A key example of this occurred midway though my fieldwork when certain campus rules were changed. Under the new rules, only residents who were on "Gold" status could walk around the grounds unescorted.[5] The rationale of this new rule was two-fold: to tighten security on the campus and to give residents added incentive to reach "Gold" status. Cottage Staff saw this rule as illogical and unfair, however. Residents enter and exit their cottages frequently throughout afternoon hours, whether to go to after-school tutoring, therapy, campus jobs, or recreational activities. Under the new rule, one staff member would have to leave the cottage to escort residents (sometimes only one resident), thus leaving fewer staff in the cottage to supervise the remaining residents. A Child Care Worker described her problem with this to me clearly: "With two staff you can't have one staff take certain kids out and one staff in the cottage with 12 kids.

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5. As described in chapter 2, residents are ranked weekly by their Cottage Manager as being on "Gold," "Silver," or "Bronze."

It doesn't work like that. They're asking us to do things that don't even add up" (Interview, November 4, 2010). Even as Cottage Managers and Child Care Workers acknowledged the financial constraints faced by the institution in hiring new staff, comments about how cottages are understaffed were consistent throughout my time at Edgewood.

On the Side of Treatment

As cottage workers grapple with concerns about communication and respect, as well as the demand to work efficiently with fewer staff, Edgewood staff who work outside of the cottage face different challenges related to reporting requirements and discharge planning that undermine what they believe is the purpose of their job: to provide treatment to residents. Clinicians and Permanency Planners complete the vast majority of paperwork that is included in a resident's case file and is presented to the relevant authorities when the case comes up for review with external city and state agencies or in Family Court. Much of this paperwork is clearly necessary (more on the specifics of completing paperwork will be presented later in this chapter), but it also takes time away from real interactions with residents. One clinician I interviewed told me that in the past she "had a lot more time to actually do therapy" but the current environment mandated "a lot more in terms of registering the data, documenting what you've done [rather] than doing it." She provided an example of a recent directive to document every contact she had with residents—not only clinical time but also simple "hellos" walking across the campus. She repeated what she had been told: "She said, 'Yes, you'll be carrying around all of these pages of checklists, so every time you say hello or how are you doing, that gets marked off… we need to show we're making milieu contact.'" The clinician presumed she was being asked to do this in response to fear about the future of the agency. "The state has been closing RTCs, and everyone has been very worried, so the more they can document, the better,"

she surmised. Apart from finding this "onerous and irritating," the clinician felt such a checklist would take time away from more substantive exchanges. "When do we do therapy?" she reported asking the woman (Interview, November 3, 2010).

This clinician was not unique in her assessment that there is little time for therapy on the campus. However, not everyone tied this fact to reporting requirements alone; some felt that the agency undervalued the role of therapy on the campus. "A clinical focus or clinical interventions isn't always the norm across the campus, or isn't always seen as the norm across the campus," one clinician told me. "The trips, and work, and other things are more important, it seems, than clinical time. If this is supposed to be a therapeutic environment, I would think clinical services should be pretty important" (Interview, September 25, 2010).

While clinicians feel there is not enough time to do what they are hired to do, Permanency Planners feel they are being asked to "move cases along" at rapid speed no matter what obstacles stand in their way. One Permanency Planner reflected in an interview:

> We're at a stage where it's "get it done" and it can't get done, just "get it done," but they're not realizing the different entities that play a big part. Whether it is court, whether it is permanency, whether it is family, whether it's the youth, whether it's mental health services, there are a lot of entities that play a part of moving cases along, and it's not so much of doing the clinical work any more. It's moving the cases along, whether they're ready or not, let's get it done, get it out. That's a barrier that is hard to try to penetrate and get past. [Interview, October 28, 2010]

The sentiments expressed in this narrative are remarkably similar to the views expressed by staff in the emergency psychiatric unit Rhodes (1991) studied, where the mantra is one of "emptying beds." There, too, hospital workers had to liaise with multiple outside agencies in the service of getting patients discharged. Yet, whereas the people in Rhodes' study were proud of the efficiency with which they discharged patients (in comparison to the "dilly-dallying" of their counterparts), the narrative above suggests that Permanency Planners at Edgewood struggle with

the efficiency asked of them. They hope for a return to work that is more clinical and less about acting as a go-between among agencies, residents and families.

Friction at the Divide

Given that the positions staff occupy shape their perspectives and concerns about their work, it is not surprising that there are moments of confrontation—both direct and indirect—among staff at Edgewood. I describe three such moments here that speak to the challenges of working together across the custody/treatment divide. The first elaborates on the tension surrounding the demand to move residents' cases forward whereas the second and third address divergent perspectives about how to address the clinical needs of residents. My intention is not so much to draw attention to the fact of conflict itself (inevitable in any organization) but to highlight how these conflicts speak to broader issues about the conceptualization of residents' needs and competing philosophies about how to best meet those needs.

<u>"Moving Cases Along"</u>

Because responsibility for residents is dispersed among multiple staff at Edgewood, conflicts inevitably arise over the division of responsibilities and the question of whether people are working "hard enough" to move residents toward discharge. In the example I present here, a Cottage Manager suggests that a Permanency Planner is not fulfilling her job responsibilities and is therefore delaying the goal of discharge.

> *Ms. Williams [Thayer's Cottage Manager] arrived late to Rounds today and when she sat down I could feel the added tension she brought to the table. When we got to Jasmine's case, Ms. Williams asked the Permanency Planner, Ms.Carter, why Jasmine couldn't go on home passes to her adult sister's house.*

> *Ms. Williams*:   She can't go home? Nothing? Day pass? Nothing? She needs
>   something new… she has no motivation to do anything. Have you

seen her appearance? It's gone downhill. Her spirit is just not the same.

Ms. Carter: We have to be careful because she had the stabbing and choking incident. [Referring to a past incident where Jasmine's sister accused Jasmine of assaulting her boyfriend while visiting them].

Ms. Williams: It's really hurting her that she can't go home.

Ms Carter: I need to check with [a separate visiting resource for Jasmine that she might be able to start seeing again] to think about a safety plan if this sort of thing happens again.

Ms. Williams: Every week we come here and talk about the same thing but nothing happens after we leave.

The contrast between Ms. Williams' point of view here and the point of view of the Ms. Carter is remarkable. Whereas Ms. Williams is concerned about Jasmine's demeanor *within* the cottage, Ms. Carter is concerned about Jasmine's behavior *outside* the campus (specifically, Jasmine's potential for violence and the responsibility she would bear if Jasmine hurt someone on a home pass). The exchange is one of many in my field notes where Cottage Managers inquire about why a resident's case does not appear to be moving forward. Even as Cottage Managers acknowledge the difficulty of resolving certain cases, they also criticize other staff for allowing residents to stay at Edgewood too long. Ms. Williams elaborated on this in our interview:

> You have the kids that are here too long and [Edgewood] kind of sets them up for failure because this is not reality. The life they live here is just not reality. If you're here too long, you can't function when you go out there because who is waking me up in the morning? My school is not two steps in front of me. I don't have staff keeping me in line. It kind of sets them up.[6] [Interview, November 3, 2010]

Viewed from this perspective, the conflict between Ms. Williams and Ms. Carter about Jasmine's home passes reflects a larger divide in beliefs about how long residents should stay at Edgewood. Ms. Williams was not alone in her view that residents stayed at Edgewood "too long." One

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6. Interestingly, this comment by Ms. Williams echoes earlier arguments made by the community psychiatry movement about the negative effects of long-term hospitalization (see Grob 1991).

clinician echoed Ms. Williams' sentiments when she told me that keeping kids on the campus was "not in the pattern of making them self-sufficient" (Interview, September 25, 2010). But this issue is not easily resolved and, as demonstrated earlier, Permanency Planners feel enormous pressure to fast-track cases. Thus, even if Permanency Planners agree that some residents stay on the campus too long, they are likewise sensitive to the fact that cases (and the ability to move cases along) are beholden to multiple systemic factors over which they have only the most limited control.

The Structure and Delivery of Clinical Services

Related but subtler conflicts occur regarding the clinical treatment of residents. The reorganization of the Clinical Department in June 2010 was done under the premise of increasing accountability and transparency. During my interview with the then Director of Performance Management, Alison, the reorganization was described as a move "to have less middle-management and more focus on what [is] really happening." Thus, some positions were eliminated entirely and certain clinicians were assigned to different cottages. Alison elaborated:

> It wasn't clear what caseload each clinician had, and it wasn't clear for those clinicians who were seeing kids individually for therapy what their treatment goals were, and whether they were reaching their treatment goals because it wasn't clear. Also it wasn't clear that the clinicians were working open and transparent, and in a standard practice in all of the cottages with the cottage manager, so what information they did have wasn't being shared in a systematic way. Part of my taking over the management of it was to improve those functions so that as kids were receiving clinical treatment, it was clear what type of treatment they were getting and towards what end, and how that information could impact the program, both while the residents are here and to help them transition back to their families, also to increase greater communication with the families, and also not to duplicate services intentionally. [Interview, October 28, 2010]

Despite the desire to improve communication and transparency, "it is not clear" that the clinicians themselves understood all the reasons for the reorganization. One clinician told me that while she was glad the Director position was eliminated (for personal reasons; she admitted to

not getting along with the Director), "all of the rest of the changes that followed seemed absurd to me, or having no reason that was clear, and everybody was rolling around thinking they had no idea what they had done." Some clinicians were demoralized by the changes. "I'm disappointed in what is going on clinically here… I feel there was change, really positive change in the wind, and now they didn't really meet my expectations (Interview, September 25, 2010). Others were less concerned about the direct impact on the clinical team than they were about the message it sent to staff in other areas: "I won't say it demoralized clinicians, but it made the rest of the campus look at clinicians like something was wrong, like why are you being ripped out of your cottage you've been in for three years? I feel like it sent a very bad message to the rest of the campus" (Interview, November 3, 2010).

Indeed, during my interviews with cottage staff and Permanency Planners after the reorganization, it was evident that the restructuring had not been communicated well and that, in turn, many questioned the efficacy of clinical services at Edgewood. For these individuals, "clarity" and "transparency" were not driving concerns; they simply wanted more clinicians who could spend more time with residents. As Ms. Williams told me, "The clinical services, I think it's too little, and they have too many kids for them to see for them to be really effective. They don't have time to sit down. I feel the kids' issues are not being dealt with" (Interview, November 3, 2010). Two Permanency Planners echoed this. One commented, "There is very few staff to deal with the amount of kids we have on campus" (Interview, November 2, 2010). Another reflected, "I believe there is not enough clinicians to handle the extensive backgrounds that these youth are coming in with… I don't believe the clinical department is operating to the fullest of its capacity at this time" (Interview, October 28, 2010).

In Thayer Cottage, where several clinicians had been assigned and reassigned to the cottage in a short period of time, the impact of the reorganization was felt most intensely. When I asked a Child Care Worker in Thayer what she thought about the clinical services offered on the campus, she responded with sarcasm, "What clinical services?" She clarified what she meant:

> Honestly, I don't know. I honestly don't think they're getting the treatment they need. I don't think so. I think they need intensive treatment, and I don't think it's a priority, or if it is, I'm not seeing it. Kids will say I want to talk, I want to talk, but sometimes they do talk and I don't know what results they're getting from it, because no one comes back with follow-up or anything. I don't know… I think it's [clinical services] nonexistent as far as I'm concerned. [Interview, November 4, 2010]

Such a negative view of clinical services was accompanied by a certain amount of distancing from work in this case. Rather than wanting to know more about residents' clinical needs or their treatment, this staff member questioned whether such information might compound her already negative views of treatment on the campus:

> I don't know which one is worse, knowing that they need certain treatment [and] they're not getting it, or not knowing. You understand what I'm saying? You kind of set yourself up knowing "oh my God, this child has certain issues that their needs are not being met." Then how do we deal with that in the cottage? We can only extend ourselves so far. [Interview, November 4, 2010]

In this case, the Child Care Worker maintained a critical stance toward the treatment team at Edgewood while also adopting a defensive posture about the boundaries of her own work. Feeling that a focus on reorganization had been prioritized over the delivery of actual clinical services, this particular staff member seemed to suggest that she should not be held accountable for this shortcoming.

<u>Medicating Residents</u>

An additional conflict in the realm of clinical treatment that was more peripheral during my fieldwork but deserves mention here is related to discordant philosophies on medicating

residents. There are two primary people in charge of medication at Edgewood: the part-time psychiatrist who is on campus one morning a week, and the part-time psychiatric nurse practitioner who is on campus four days each week. The psychiatrist prescribes all medication for youth and the psychiatric nurse practitioner is charged with medication monitoring, meeting with all residents on medication at least once a month.[7] In my interviews with the Director of Performance Management, Alison, and the psychiatric nurse practitioner, Ms. Parsons, both individuals emphasized that the "philosophy" at Edgewood was to minimize the use of medication while acknowledging it can be necessary for and helpful to residents. They described this philosophy in similar terms. Alison reflected:

> Our clinicians are very concerned with the numbers and the dosages of medication that our kids are on and that it really is required. I would say we really minimize the use of medication, but we also appreciate the impact of medication on certain kids and the necessity for them to continue their medication regimen if it's helping them. [Interview, October 28, 2010]

Ms. Parsons relayed similar sentiments: "this is the philosophy… I work with [psychiatrist] on this. What we want to do is we want to have them appropriately medicated so that if they need medication, we want them to have it" (Interview, November 10, 2010).

While minimizing the use of medication may be the ideal, adhering to that ideal in practice is made difficult by the fact that many residents come to Edgewood on multiple medications. Ms. Parsons explained:

> Most of the time we find when they come in there has been a whole process of additional medications because they have been having problems. They wouldn't be here if they didn't continue, so they will come in on three or four medications, and so what we try to do is we try to gradually take them off one by one to see what is the best level of medication, and how we can get it down to one or two to meet their needs [Interview, November 10, 2010]

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7. As of the fall of 2011, 39 percent of Edgewood residents were taking psychotropic medication. This number is consistent with the literature on rates of medication use among youth in child welfare (Leslie et al. 2010:135; Breland-Noble et al. 2004:707, Connor and McLaughlin 2005:307, Handwerk et al. 2008:523). I will address medication with more detail in chapter 5.

The goal of minimizing medication use is challenged by the reality that many residents have had long histories of being medicated with various psychotropic drugs. This raises important questions about what is configured as an "appropriate" level of medication, questions I will return to in chapter 5 when I introduce resident perspectives on medication.

As it relates to staff interactions, however, it became clear to me during my fieldwork that even if those who prescribed medication stated a desire to minimize its use, other staff on the campus had quite different perceptions on how medication was being used in treatment. On the one hand, there were always comments in Rounds about how a particular resident "needs to be on meds." Such comments, often said in a flippant manner, appeared most often as emotional reactions to discussion about a particular resident and the trouble she was causing in the cottage at a specific moment. On the other hand, there remained real concern on the part of some nurses and clinicians that medications were being prescribed inappropriately and too frequently. Ms. Margaret, the nurse for Hamilton and Thayer Cottages, for example, took issue with the fact that the psychiatrist often prescribed Benadryl as an additional medication for youth who complained of trouble sleeping; she felt that youth were manipulating the psychiatrist to get Benadryl because of its use as a recreational drug (Benadryl's active ingredient, diphenhydramine, is associated with elevated mood; see Thomas et al. 2008 for a description of the abuse potential of diphenhydramine, particularly among people already taking prescribed antipsychotics).

In a similar vein, Ms. Margaret was concerned with how medications were being managed when residents went home over the weekend. While nurses administer medication to residents during the weekdays, residents receive two days worth of medication to take home with them if they get a home pass for the weekend. Ms. Margaret's problem with this practice was twofold: she feared that some residents were selling their medications for profit rather than

taking them ("Seroquel is everyone's favorite at the train station") and that other residents were continuing to take their medication as prescribed while also smoking marijuana and drinking alcohol. Ms. Margaret indicated to me that she wanted to suggest that medication not be given to residents who went home on the weekend because she felt it was safer to have residents off medication entirely than selling them or using them in conjunction with recreational drugs. During my fieldwork, however, Ms. Margaret's suggestion was never elevated as far as I know. In addition to the fact that the psychiatrist was on campus only one day a week (and thus very busy when he was there), it is clear Ms. Margaret, as well as other nurses and clinicians, felt him to be unapproachable and out of tune with the everyday realities of the campus.

The Burnout Effect

I have been using the idea of a custody/treatment divide to describe the different perspectives of staff at Edgewood. Admittedly, this is a simple heuristic that cannot account for the complex views that staff hold about Edgewood and its treatment of youth. As the examples I provided demonstrate, alliances among different staff may shift depending on the particular issue at hand. I think the idea remains useful, however, to the extent that it demonstrates how staff are oriented to fundamentally different concerns depending on their position within the organization and that their orientations conflict with each other in important ways.

Despite these various orientations, it is clear that many staff across positions at Edgewood feel similarly worn down by the demands of their jobs. Karasek's model of job stress suggests that jobs with high psychological demand (qualitative emotional demands and quantitative demands) and low decision latitude experience the highest levels of stress; workers in these jobs are most likely to report exhaustion, depression, and anxiety, and are at elevated risk for myocardial infarctions (Karasek 1979:292; Theorell 2001:96). These two dimensions—

high demand and low decision latitude—can apply equally to Edgewood staff on both sides of

the custody/treatment divide, although in different ways. All staff at Edgewood have high

demands placed on them by virtue of working in a residential treatment environment. But

whereas cottage staff, for example, experience these demands alongside relative powerlessness

to effect change within the organization, Permanency Planners must meet demands with little

power to change the institutional environment in which Edgewood operates as a placement for

youth enmeshed in multiple city and state agencies. Thus, although burnout among "direct line"

staff has been cited widely in the literature on residential treatment (Decker et al. 2002;

Eastwood and Ecklund 2008; Freudenberger 1977; Maslach et al. 2001; Rose et al. 2010; Seti

2007), it may apply equally to individuals across multiple roles at Edgewood.

The concept of "burnout" is too vast to take on comprehensively here and merits its own

study in an environment like Edgewood. But the defining characteristics of burnout—

"overwhelming exhaustion," "feelings of cynicism and detachment from the job," and "a sense

of ineffectiveness and lack of accomplishment"—are clearly on display at Edgewood (Maslach

2001:399). I have already touched on some of these themes when discussing the conflicts among

staff members at Edgewood. In particular, the negative views on clinical services suggest some

staff feel youth make little therapeutic progress on the campus. Meanwhile, staff working in

cottages or in Permanency Planning express high levels of exhaustion that impact their

willingness to stay in their current positions. Such feelings were conveyed to me both in casual

conversations—where staff asked me, only half-jokingly, if I could find them a new job—and in

longer interviews; not a single Permanency Planner, Cottage Manager or Child Care Worker I

interviewed envisioned themselves staying in their jobs. Some of the responses I received when I

asked staff if they could see themselves doing the same job in the future included, "My gosh,

no!" "It's too much… I can't do it anymore," and "If I had to do this [job], no [I wouldn't stay]."

One Permanency Planner mentioned "burnout" directly. "Personally it's too much," she

reflected. "It's a burnout and I haven't learned how to balance everything at one time. It requires

a lot of multitasking. It requires a lot of diligent effort, and personally I feel that I'm getting

burned out" (Interview, October 28, 2010).

It is essential to note that even as staff express frustration with their jobs, they likewise

maintain that they truly enjoy working with youth. As a Child Care Worker noted:

> You get up every day and you say I wish things were different. I don't want to work here any more. Things could have been better, but at the same time you do love your job. The pay sucks, but it's a pleasure to come to work with some of the kids and try to make a difference. If I have to think about my pay every day, I would not come to work at all. I'm sure there are other jobs out there that pay a lot more, but for whatever reason, every other day I feel like I love working with kids. [Interview, November 4, 2010]

The same Permanency Planner who mentioned burnout associated with multitasking also

focused on the value of "making a difference" for even one resident:

> We may not see the fruits of the labor now, but eventually you will… there are good staff, good youth, and people pouring into them so they will become better citizens when they grow up. I guess that's the greatest part of the job… when you know you're making a difference and you're not just here to get a paycheck. Even after the tough time, that one impact with youth means the world. [Interview, October 28, 2010]

Coming from the very same people who told me that they did not anticipate staying in their

current jobs for the long term, these expressions of investment in Edgewood residents point to a

complex relationship with work. As Ms. Williams told me, "I don't know, I love it though. I do. I

hate it, but I love it. I do love it" (Interview, November 3, 2010). In the space of reflection, these

staff voice a deep commitment to their work. In the next section, I demonstrate how this

commitment is maintained over and above competing philosophies about how to serve residents

by examining the staff experience in biweekly Rounds.

MAKING IT WORK IN ROUNDS

Rounds is an important arena for understanding working relationships at Edgewood because it is one of the few cross-departmental meetings that occur regularly on the campus. Held on the first and third Wednesdays of every month, Rounds are intended to be the primary site for the exchange of information about residents. During my fieldwork, Rounds often served as an arena for conflicts to play out; many of the examples already discussed in this chapter occurred during Rounds. At the same time, Rounds served to unite staff in two important ways, one practical and the other emotional. I describe each of these purposes in turn after a brief description of what happens in Rounds.

When staff gather for Rounds, each cottage is assigned to a single table. There is generally a core group of people at one table for the cottage (Cottage Manager, Permanency Planners, Clinician and Nurse). Additional people sit down to the table when a particular resident comes up for review (Substance Abuse Counselors and some Permanency Planners cover residents across cottages so will travel between tables to give updates on residents they work with). Staff from the Edgewood school are also supposed to attend Rounds but none were present during my research, likely because Rounds occur in two shifts that coincide with the school day (one group of six cottages meets from 12:00 p.m. to 1:30 p.m. and the second group of six cottages meets from 1:30 p.m. to 3:00 p.m.).

Once everyone is gathered at the table, one person takes responsibility for entering notes on the computer. Staff then proceed to go through the cottage census and provide updates on each resident in the cottage. For the first several months of my fieldwork, the updates provided in Rounds were not done according to a specific format but rather included whatever information staff found relevant; this usually entailed discussing how the resident was behaving inside the

cottage, how she was doing in school, and any new details about her discharge date. In May 2010, however, Permanency Planners decided to change the organization of Rounds so they could gather the exact information required for their monthly reports. For each resident, the group in Rounds was asked to provide the following information (with the verbal explanation of each given by a Permanency Planner): (1) Discharge date; (2) Cultural Competence (List how the child identifies racially and ethnically, as well as list their gender orientation and sexual orientation); (3) Gang affiliation (List whether or not the child is in a gang); (4) Cottage Functioning (How are they behaving in the cottage?); (5) Education (How is the child doing in school?); (6) Youth development (List what activities in the child is involved in); and (7) Safety (Is the child a safety risk?).

Writing to Write

It is clear that Rounds are a place where Permanency Planners can gather the information necessary to write their monthly reports. The fact that this information comes from various sources means staff must work together to produce information and enter it into a standardized form on the computer. Collectively, staff across departments produce a record for each resident that may have multiple future purposes: records are used to justify discharge, to provide evidence to insurance companies when a resident needs to be hospitalized, and are an essential part in "covering your ass" (Rhodes 1991:109). Similar to the reports written by probation officers and court psychologists described in chapter 2, the narratives produced in Rounds are narratives with a job to do (Garfinkel 1967).

To the extent that the reports created in Rounds may be administratively useful to staff throughout the Edgewood organization at various points in time, they also serve another purpose: to unite staff in resistance to what one staff member called the "obsessive-compulsive approach

to documenting" on the campus (Interview, November 3, 2010). Despite the supposedly good intentions behind streamlining Rounds, the new format was also problematic because it was simply impossible to cover all of the required information for every resident within the allotted 90 minutes. Thus, some residents were never covered at all within Rounds and methods were devised to meet the demands of the report efficiently while not actually treating the report as central to the discussion. When describing how a discharge date needed to be written in each report, for example, one Permanency Planner explained, "A date must be listed even if it is artificial." Thus, even though discharge dates were almost never known far in advance, staff went about putting in artificial dates to fulfill the goals of the report. Over time, staff learned to copy and paste old information into the new form or to put simple answers that conveyed little but still met the technical demands of the report. The result was similar to what Rhodes described as occurring in the emergency psychiatric unit: "Under these circumstances [the chart] became a covertly ironic commentary on its own pretension to transparently represent what staff called the 'reality' of the unit" (1991:111). That is, staff knowingly created a report that offered little insight about residents but that met reporting requirements while allowing them to carry out Rounds as they preferred (with long discussions about individual residents).

Bonding Through Humor

Insofar as Edgewood staff united in subtle resistance to the new format of Rounds, they also came together for perhaps a more important purpose in Rounds: to demonstrate support and solidarity in an enormously stressful environment. Rounds are one of the few places where staff can meet without the interruptions of residents and, as such, they create a space of adult interaction where staff can be freed temporarily from the propriety that is required in their dealings with youth and their families. In this setting, I found humor was invoked frequently as

an emotional language with which staff could index the sense of absurd that runs through much of their work.

Much has been written on the function of humor, from its use as a coping mechanism in stressful work environments (using an old-fashioned, functionalist approach: Kuhlman 1988; Kuiper et al. 1993; Moran and Hughes 2006; Siporin 1984; van Wormer and Boes 1997), to its utility in therapy and crisis intervention situations (Lachmann 2005; Pollio 1995), to its influence on physical health (see Martin 2001 for a review of the literature). Freud writes about humor directly in an essay where he praises its "fine and elevating" characteristics: "Obviously, what is fine about it is the triumph of narcissism, the ego's victorious assertion of its own invulnerability. It refuses to be hurt by the arrows of reality or to be compelled to suffer. It insists that it is impervious to the wounds dealt by the outside world, in fact, that these are merely occasions for affording it pleasure" (1928:2). Building on Freud, other scholars have taken humor out of the psychoanalytic realm and into everyday interactions. In writing about a maximum security forensic unit, for example, Kuhlman (1988) takes up Freud's statement on humor as the guiding definition of "gallows humor"—the genre of jokes about the condemned man about to be hung on the gallows who, despite his hopeless situation, manages to transcend his malaise with clever repartee. Kuhlman gives an example: "When the executioner offers [the condemned man] a last cigarette before the blindfold, he responds: 'No thanks. I just quit yesterday'" (1988:1085). Kuhlman examines the use of gallows humor as a coping mechanism in what he calls "scaffold settings," contexts in which there are "unremitting or inescapable stressors over where there is minimal control and a sense of existential incongruity" (1988:1086). He argues that such humor is a "broad philosophical attitude" toward irresolvable dilemmas and "offers a way of being sane in an insane place" (1988:1085). Below, I present two examples that

demonstrate how a humorous attitude was activated during Rounds to help staff deal with the inescapable stressors and incongruities of their jobs. I argue that humor boosts morale and strengthens group solidarity by providing an outlet for stress that would otherwise be debilitating and by reaffirming commitment to one's work.

Mama Gorilla and her Baby Gorillas

During my research at Edgewood, one of the obvious stressors was the presence of gangs on the campus. As described in chapter 2, many staff articulate their sense that youth on campus are tougher today than in years past and also more brazen about their illicit activities, whether by smoking marijuana directly in front of the school or "walking around throwing up gang signs, whether there are adults around or not" (Interview, November 4, 2010). Staff toe a fine line when it comes to gang activity because while they recognize that gang involvement may serve many purposes outside of the Edgewood campus (protection, or a sense of community, for example), they have no tolerance for it on the campus. As one Assistant Director of Group Living told me, "We're very clear. Those are your affiliations. We understand, but once you bring it past the gate it becomes our issue because it affects the program. It affects how you look at other peers who are not in the same gang as you are, and what your response to what they do and say is. Then it affects safety" (Interview, October 27, 2010). The need to keep the campus safe implies, in this case, that gang activity will not be tolerated.

Despite the clear prioritization of safety, responding to gang activity is much more complicated than merely telling residents that their behavior is not tolerated. In Thayer Cottage during the fall of 2010, it became evident that a 20-year-old resident who was close to aging out of the foster care system (youth in New York State are entitled to foster care until they turn 21

years old) was recruiting Thayer residents to join the Bloods and report to her.[8] This resident was

holding meetings 2–3 times per day on campus and attendance at these meetings was mandatory,

even if it meant cutting class (the resident herself had already graduated from high school so was

not required to be in the school building during school hours). The supposed secrecy of these

meeting was belied by the fact that "recruits" in the gang were giving information about the gang

to staff members within Thayer; one staff member found a notebook listing all the rules of the

gang and photocopied it for the administration. In the process of discovering more information,

staff learned the leader of the gang was known to her recruits as Mama Gorilla. Under Mama

Gorilla's leadership, the girls in the gang "jumped" (i.e., beat up) another resident for missing a

meeting, threatened other residents regularly, stopped listening to staff, and began spending more

and more time AWOL at an off-campus apartment that had been secured by the campus for

Mama Gorilla in her transition to independent living.

Staff felt that their hands were tied in this situation. They were legally responsible for this

resident and had been told that they could not yet discharge her. To some extent, I think they also

feared what the resident's response would be if they asked her to leave the campus. The Vice

President of Edgewood did speak to the resident directly, telling me he had taken her for iced

coffee at Starbucks off campus ("Because where do you take a leader of the Bloods?"), and had

informed her that he would call the police if he found out she had invited other residents to stay

at her new apartment. He also admitted to me, however, that calling the police might not be in

the best interests of the campus—the police might send her back to Edgewood. Meanwhile,

8. The Bloods, originally founded in Los Angeles, California, are a street gang with "sets" throughout the United
States. The New York arm of the Bloods, United Blood Nation, is said to have formed within Riker's Island
detention center in 1993 (GRIPE 2007). It is unclear whether the group at Edgewood was in fact part of an
established "set" of the Bloods or whether they were an offshoot that merely identified with the Bloods. Research on
modern youth gangs suggests that many gangs bear the names of earlier gangs that originated in Los Angeles but
have little or no real national affiliation (Starbuck et al. 2001).

outreach efforts to other agencies failed. Edgewood staff called OCFS to inform the agency that two juvenile justice residents were living at this off-campus apartment on the weekends (and eventually for weeks on end), something clearly in violation of the terms of their disposition and grounds for arrest and modification; yet OCFS did nothing during the time I was in the field.

Despite feeling hopeless about how this case would resolve, staff at Rounds greeted information about Mama Gorilla with a growing sense of humor. They rarely used the resident's name anymore, instead relying on her nickname of Mama Gorilla. In addition, they began talking about the gang recruits as "Baby Gorillas"—something they made up on their own. The fact that OCFS would not pick up the "Baby Gorillas" now became cause for laughter, indexing the absurdity of the situation. As Kuhlman writes, "How can one master such a situation except with humor?" (1988:1087). These staff knew that there was little they could do until Mama Gorilla turned 21 and that they had to continue working with her and her recruits as residents entitled to services at Edgewood. In having to treat residents they may have felt were no longer deserving of treatment, staff used humor to carry on beneath enormous stress.[9]

Hospitalization

Kuhlman argues that scaffold settings must have an incongruous element, in addition to prolonged stress, for gallows humor to arise; "this incongruity may reside in the clash between the idealized expectations of society and what can be reasonably achieved. Or there may be great imbalance between one's efforts and the outcomes of those efforts" (1988:1087). Kuhlman also describes how "a purer form of incongruity arises when there is a reigning existential paradox

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9. To the relief of both administrators and staff on the campus, the situation was ultimately resolved. In following up with staff after the conclusion of my fieldwork, I learned that "Mama Gorilla" was officially discharged and had not reappeared on the campus. One of the OFCS residents that had been AWOLing to her apartment was eventually "remanded," however, and sent to a secure facility at another location in New York.

under which one must labor"—for example, medics on a battlefield who are charged with saving the wounded so they can return to the battlefield and be exposed to more wounds (1988:1087).[10]

This type of paradox emerges at Edgewood when staff decide to hospitalize a resident. At Edgewood, hospitalization serves as an intervention when staff are concerned that a resident is a harm to herself or others on the campus. It is widely acknowledged by staff and residents, however, that hospitalization is also used to give residents a "break" from the campus and to give staff a break from a particular resident. This might be thought of as a form of "punting" that researchers working in hospital settings have written about (Mizrahi 1987; Rhodes 1991)—what Rhodes (1991:75) calls "the game of hot shit." The paradox is that even as staff hope a resident's behavior will improve or at least stabilize at the hospital, they do not want the resident to improve too quickly; the faster a resident improves, the faster she will be returned to Edgewood.

In Rounds, then, staff sometimes quip that they are praying for a resident to act out during their stay in the hospital. Such was the case with Emily, a resident in Hamilton during my research. Emily had a pattern of violent behavior at Edgewood that included breaking windows at school, destroying the wardrobe in her bedroom, and fighting with other residents. Clinicians put a considerable amount of work into finding a hospital bed for her on more than one occasion. Each time, however, the hospital would report that Emily was not acting out and was "just depressed." Staff became increasingly frustrated that the "the hospital [did] not see her as psychotic" and hoped that Emily would act out at the hospital so she would not be discharged.

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10. Interestingly, this exact subject is taken up by Pat Barker (1991) in her novel, *Regeneration*, where she explores the predicament of the anthropologist and psychiatrist W.H.R. Rivers during World War I. Barker re-imagines the relationship between Rivers and one of his most renowned patients, the poet Siegfried Sassoon, who was sent to a mental hospital while serving in the war because of his opposition to it. The tension of the novel is centered on Rivers' predicament of having to "diagnose" (and thereby exculpate) Sassoon's opposition to the war and then "cure" Sassoon so that he might return to the same trenches that unraveled him in the first place.

This did not occur and Emily was discharged to Edgewood after a few days or weeks on several occasions, only to be re-hospitalized soon after.

The additional irony in the case of Emily is that while staff did not want her to come back to the campus, they also knew Emily had to return in order to be deemed ready for permanent discharge from Edgewood; in April, the judge in charge of Emily's case had intended to order a trial discharge but delayed this upon hearing that Emily was back in the hospital. The Permanency Planner overseeing Emily's case was increasingly despondent about Emily but turned to humor to address the situation. "We need a support group on Emily," she announced with laughter in Rounds one day. The rest of us laughed too, knowing what a challenge the Permanency Planner faced and cognizant that there were few options that would improve the situation. The laughter, at least, reminded the Permanency Planner that she was not alone in her work and that other staff appreciated the formidable task ahead of her.

Speaking through Humor

Some researchers disdain the use of humor in social work settings, arguing that it violates ethics to employ humor at the expense of "patients" (see Mizrahi 1997, for example). To level such charges, however, misses the point that humor employed in stressful work environments like Edgewood is more about the emotional survival of staff than it is about "patients." I am convinced of this latter understanding of humor's purpose because I attended biweekly Rounds for 11 months and found the humor within them to play an important role in strengthening my own spirit. Although in my role as an anthropologist I had the luxury of not having to respond directly to events on campus (i.e., I didn't have to take Mama Gorilla to Starbucks or find Emily a hospital bed), the overarching stressors that exist in a place like Edgewood undoubtedly took a toll on me, often leaving me hopeless about the multiple problems residents faced. In attending

Rounds, I had the opportunity to take part in a lighter set of exchanges that provided me with a space of relief and reminded me of my growing relationships with staff at Edgewood. Laughter provided for momentary escape and became "a language of solidarity, the vehicle of emotional expression that is used to establish and reinforce ties" (Kuhlman 1988:1089). Under such enormous burdens, to what else can staff be expected to turn if they want to endure?

Rhodes (1991), meanwhile, gives us another way to interpret humor in Rounds that goes beyond its role in neutralizing stress. "To say that the humor expressed in these situations was a safety value, a way to deal with tension, is to trivialize it," Rhodes writes. "The staff used humor to say something about themselves; through it they said, in a multitude of ways, we are *here* and no place else. Only from this angle, within this particular line of vision, can these things be seen as funny" (1991:166). Understood in this way, the humor employed by Edgewood staff in Rounds can be seen as both commentary on their commitment to work and recognition of their unique worldview as employees in a residential treatment center. In this sense, it both builds solidarity and defines the boundaries of membership in a very particular line of work. The things staff laugh about in Rounds would not be funny outside of the meetings (and even would be considered inappropriate in some settings, such as in face-to-face meetings with parents). United in Rounds, however, staff can use humor to push the limits of what can be said while mutually—and tacitly—acknowledging the difficulty of doing good in the environment in which they work. To laugh about Edgewood is to make a statement about moral membership within the organization and to reaffirm that one still works there no matter how tough the going gets.

CONCLUSION

The purpose of this chapter was to demonstrate how working relationships at Edgewood emerge from—and are shaped by—the specific staffing structure on the campus as well as the

broader external environment in which Edgewood exists. Even though my research is focused primarily on the residents who live at Edgewood, this study would be incomplete without an understanding of staff roles as well as the staff dynamics that emerged during the course of my research. The people who come to work at Edgewood every day do so under conditions that are far from ideal. They earn low salaries that often require them to take a second job, they feel that they command little respect, and they work with troubled youth for whom Edgewood is a last resort. All of this work takes place within a wider child welfare environment that is unsupportive of residential treatment and in the process of phasing out institutions like Edgewood. In this context, it is entirely understandable that staff are worn down and even negative about their jobs. And, yet, many remain committed to the ideal of helping Edgewood's residents.

I employed Rhodes' (2004) description of the custody/treatment divide in this chapter because it provides a useful way to think about why Edgewood staff perceive their work in the way that they do and how conflicts may arise directly as a result of these different perceptions. Of course, this is not a strict divide, and staff working inside and outside of residential cottages may attend to both "custody" and "treatment" functions in the course of their daily work. Even so, there is a significant difference between working directly with residents inside of their cottages and working with residents at specified intervals or in the space of a personal office. The divide is an important one, not least of all because it impacts staff attitudes about each other and may heighten stress in an already difficult working environment. It also reminds us that figuring out what is "best" for residents is highly contested and always subject to competing philosophies about who residents really are and what needs they have.

Insofar as tension is inevitable among staff in different positions at Edgewood, so too do staff recognize that they are united in mutual dependence. Within the space of Rounds, staff

come together to fulfill the sometimes absurd institutional requirements and to reaffirm their commitment to working in a place that tests their resolve daily. The practices of writing reports on residents and of using humor to explain predicaments allow staff to maintain a modicum of control over their jobs while acknowledging how little control they really have.

It is worth noting that humor is not limited to staff humor about residents at Edgewood. There are multiple arenas in which humor is used; staff and residents alike find situations funny even though they are working and living in a place where stress and sadness abound. Indeed, a more comprehensive study of humor would have looked at how humor is employed in a variety of relationships on the campus—including the clinician-resident relationship—and how it may further the transformative aspects of a therapeutic environment (Lachmann 2005). I have focused on the humor that staff employ about residents in this chapter, however, because I think it tells us the most about how staff view and respond to their world at Edgewood. As Rhodes reminds, these are people who "are *here* and no place else" (1991:166).

In this chapter and the previous one we have seen how "get it done" and "do what you gotta do" are popular refrains on the Edgewood campus. Both of these phrases index the fact that there is "work" to be done at Edgewood, whether by staff, who fulfill different roles in caring for residents and bringing their cases to the point of discharge, or by residents themselves, who are given the task of "changing" before they can be sent home. In the next two chapters, I will examine how residents engage in some of this work during weekly group therapy sessions. As will become clear, such work is never straightforward and often involves creative adaptations on the part of residents with unexpected results.

CHAPTER 4
GUIDED GROUP INTERACTION

This chapter and the following chapter demonstrate how new kinds of people are made

up within the primary clinical space at Edgewood known as Guided Group Interaction (GGI). I

argue that what happens within the specific therapeutic encounter is powerfully shaped by peer

interaction—as modeled by GGI—but in ways that are both unpredictable and subversive. I

focus on GGI extensively because it is an organizing framework for the campus and because it is

the only clinical intervention that is guaranteed to reach all residents; only some residents at

Edgewood receive individual therapy despite the fact that nearly all have been diagnosed with at

least one psychiatric disorder.[1] This chapter is structured around two central arguments. First, I

look at how GGI at Edgewood diverges from the conventional model, with specific reference to

how it unfolds in two different cottages and to how residents adopt strategies of practice that

steer GGI toward particular end goals. This offers an opportunity to demonstrate how GGI can

empower female youth to help each other but also easily goes astray and exceeds the intended

limits of confrontation. Second, I consider how GGI resembles a modern form of confession in

its insistence on self-disclosure as the key to redemption. In so doing, I argue that although the

hope of GGI lies in the reconditioning of the self through peer interaction, the self that emerges

in practice is one that must be perpetually introspective but never transformed.

GUIDED GROUP INTERACTION IN THEORY

Theoretical Foundations of Guided Group Interaction

In order to understand how GGI contributes to the shaping of individuals at Edgewood, it

is first necessary to examine the model's central principles. GGI is a type of group therapy that

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1. As described in chapter 2, 90 percent of female residents who lived at Edgewood between January and October
2010 had been diagnosed with one or more *DSM* diagnoses. The mean number of diagnoses per resident was 2.32.

was developed after World War II for use in correctional institutions (Bixby and McCorkle

1952). Its core tenet holds that if the peer group is an influence in the creation of delinquency,

then so too can it serve as a corrective. As Gottfredson writes in his review of peer group

interventions, GGI "assumes delinquents must learn to conform to conventional social rules by

gaining more social rewards through conformity than through nonconformity. GGI is expected to

encourage participants to recognize problems with their behavior, attitudes, and values"

(1987:672). Vorrath and Brendtro (2007) have elaborated on GGI more recently with their

Positive Peer Culture (PPC) model, but the focus on mobilizing the power of the peer group and

the processes used to do so are fundamentally the same.[2]

Although GGI approaches were developed initially for use in residential settings with

male adolescent delinquents, they have been adopted by a wide range of programs for use with

males and females in adolescence and young adulthood. The model is now seen in a variety of

settings, from clinics and nonresidential programs, to group homes, schools, and other locations

(Elias 1980; Vorrath and Brendtro 2007). In its intended form, GGI is notable for its specific

format, its climate of trust and openness, and its emphasis on the complementary and guiding

role of the adult staff member who acts as group leader.

In terms of format, GGI is supposed to occur 3–5 times per week for 60–90 minutes with

the same group of youth. In the first part of the meeting, all youth identify problems they are

having using a universal list of labels; if a youth omits a problem, a peer may bring it to her

attention. These labels include three general problems ("Low self-image," "Inconsiderate of

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2. Vorrath and Brendtro admit that PPC owes much of its conceptual base to the GGI processes developed in the 1960s but maintain that there are useful distinctions between the two models; they argue that the PPC treatment philosophy is centrally about changing attitudes, values, and self-concept, whereas GGI is more focused on establishing self control over behavior (2007:154). Given my own review of the literature, I am not convinced that these distinctions are valid in practice. Furthermore, GGI at the Edgewood campus follows the same format as the PPC model. Thus, I treat the two models as interchangeable here. This approach has been used by others evaluating and reviewing peer interventions (see, for example, Brendtro and Ness 1982, and Elias 1980).

other," Inconsiderate of self,") and nine more specific problems ("Authority problem," "Misleads others," "Easily misled," "Aggravates others," "Easily angered," "Stealing," "Alcohol or drug problem," "Lying," and "Fronting") (See Appendix D for the full problem list with definitions).[3] Once problem-labeling has finished, all members of the group decide who should be "awarded" the meeting, choosing an individual who they believe deserves the most help on that particular day. Group members then concentrate on helping the chosen individual understand and resolve his or her problems. When this part comes to a close, the staff leader ends the meeting with a summary of what has occurred in the session.

Despite a focus on problem-labeling, the model GGI is insistent on creating a climate of trust and openness that is conducive to change. As Vorrath and Brendtro argue, "PPC is based on the application not of peer coercion but of peer concern" (2007:19). Emphasis is placed on the present and problems are seen as opportunities rather than mistakes. Thus, much time is given to allowing youth to develop a strong group dynamic. The climate that emerges is intended to give youth the opportunity to examine and experience alternatives to delinquent behavior, while giving status and recognition to youth, not only for their own participation, but also for their willingness to help their peers (Empey and Rabow 1961). Ultimately, the social rewards of conformity should make youth recognize the existing problems with their attitudes and values.

A final area that is central to the model GGI is the role of the adult staff member who acts as group leader. Vorrath and Brendtro (2007) go to great lengths to explain the important role of the group leader, whose job it is to instruct, redirect, and motivate youth while always making the peer group responsible for working out problems. They describe this individual as "stable," "warm," "interested" and "understanding"; he or she "must always behave in a mature manner"

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3. It is notable that for a program based on "positive" peer culture, there are no "positive" labels to draw from in GGI.

and "should possess leadership skills and be able to inspire confidence in others" (2007:79-80). To this end, group leaders' training is essential to the successful functioning of GGI meetings.

Evaluations of Guided Group Interaction

It is easy to understand why a therapeutic model driven by peer interaction would be appealing to a residential treatment center. There are, for instance, practical motivations for using group therapy in a place that serves large numbers of youth in a cottage setting: it is financially feasible (requiring only cottage staff for facilitation) and it creates a space for youth to come together on a regular basis and take stock of cottage dynamics. There is another appeal to using GGI in residential treatment, however, and one that is related directly to the population that Edgewood serves. An overwhelming number of Edgewood residents come from homes where adults have consistently failed them. These are youth who have been abandoned, abused, and neglected by the very people who are charged with ensuring their wellbeing. In many ways, then, peer relationships fill a void in the lives of these residents, serving as a substitute for otherwise broken bonds. The attraction of the GGI model is that it recognizes that youth do not have to be alone and that they can remake their worlds through peer support.

Even with such appeals, however, empirical evidence does not consistently support the efficacy of the intervention; experiments conducted since 1960 have come to ambiguous conclusions at best. Two early examples of research on the effectiveness of GGI are widely cited: the Highfields Project (McCorkle et al., 1957) and the Provo Experiment (Empey and Erikson 1974). In both of these experiments, promising initial findings may have been overstated because of problems in the research design. In the Highfields Project, for example, recidivism rates were compared for 16- and 17-year-old boys assigned by judges to either 4 months of probation at the Highfields residential program (where GGI was held five days a week) or one

year of incarceration at the state reformatory. While recidivism rates for youth sent to Highfields were indeed lower upon comparison, it is also true that there were important differences between the two groups of youth prior to assignment. Given the profile of the two groups of boys, it could have been predicted a priori that boys sent to Highfields would have lower recidivism rates; the use of GGI at Highfields could not be said to be uniquely influential (Gottfredson 1987:674).

There has been limited research in more recent years on GGI and PPC but the literature that does exist tends to be critical of the model. Kapp (2000) interviewed former clients of juvenile treatment facilities and found frequent and consistent negative critiques of the model. Ryan (2006) concluded that peer interventions may not be effective for delinquent and maltreated youth because the trusting relationships required by the model can be especially difficult to establish among this population. These are important findings, especially in light of evidence that positive peer culture models are still used in residential treatment facilities; a recent study of New York State residential treatment facilities by Baker et al. (2008:338) found that nearly 20 percent cited positive peer culture as the model of their therapeutic milieu.

A broader body of more recent literature looks beyond these specific models and argues that not only is the utility of peer interventions overstated but also there is evidence that peer interventions may exacerbate deviant behavior. This literature suggests that because affiliation with deviant peers is associated with growth in deviant behavior, there is reason to question whether delinquent youth should be treated together (Dishion et al. 1999; Gifford-Smith et al. 2005; Sherman et al. 1998). Gifford-Smith et al. (2005) acknowledge the very real financial and logistical constraints that make group therapy the most common therapeutic experience across settings but suggest that it is worth considering alternatives or, at the very least, learning more about how to mitigate the potential harmful effects of peer influence in group therapy.

Mapping GGI Labels onto Psychiatric Disorder

Beyond empirical studies that look at the efficacy of treating delinquent youth within group settings, it is worthwhile to think more seriously about the consequences of a model that does its primary work through labeling. I do not intend to enter into an extended discussion of labeling theory here (e.g., Becker 1963, Link et al. 1989). Consider, however, that many of the labels from GGI resemble items from a *DSM* symptom checklist for behavioral disorders. The *DSM-IV-TR* (2000) lists 15 diagnostic criteria for Conduct Disorder (see Appendix A) and eight criteria for Oppositional Defiant Disorder (see Appendix E). Table 6 displays the remarkably close fit between several of the GGI labels and diagnostic criteria from these disorders.

Table 6 Comparison of GGI Labels and Diagnostic Criteria for Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD)

GGI Label	*DSM* Symptom (Conduct Disorder & Oppositional Defiant Disorder)
Inconsiderate of others	"is often spiteful or vindictive" (ODD)
Inconsiderate of self	"often blames others for his or her mistakes or misbehavior" (ODD)
Authority problem	"often stays out at night despite parental prohibitions" (CD)
	"often actively defies or refuses to comply with adults' requests or rules" (ODD)
Aggravates others	"often bullies, threatens, or intimidates others" (CD)
	"often deliberately annoys people" (ODD)
Easily angered	"often loses temper" (ODD)
	"is often touchy or easily annoyed by others" (ODD)
	"is often angry and resentful" (ODD)
Stealing	"has stolen while confronting a victim" (CD)
	"has stolen items of nontrivial value without confronting a victim" (CD)
Lying	"often lies to obtain goods or favors or to avoid obligations" (CD)

As described in the introduction, the history of "Disruptive Behavior Disorders" is a relatively recent one; Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD) only entered the lexicon of psychiatric disorder with the publication of the *DSM-III* in 1980.[4] Today,

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4. Notably, just seven years after the appearance of the *DSM-III*, the American Psychiatric Association published the *DSM-III-Revised*, explaining that "despite extensive field testing of the *DSM-III* diagnostic criteria before official

however, these two diagnoses are the most common reasons for the referral of children and adolescents to outpatient mental health clinics and residential treatment centers (Kimonis and Frick 2010:244). The essential feature of CD is "a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated," and the essential feature of ODD is a recurrent pattern of "negativistic, hostile, and defiant behavior" which "leads to significant impairment" (APA 2000). Importantly, there has been considerable dialogue on the extent to which CD and ODD relate to, and should be distinguished from, one another (Loeber et al. 2000; Mallett 2006). Although a diagnosis of ODD currently cannot be given if a child or adolescent has already been diagnosed with CD—because of the belief that "ODD appears to be a milder developmental precursor to early onset CD sharing similar risk factors and a common etiology" (Kimonis and Frick 2010:245)—it seems clear that the two patterns of behavior encapsulated by these disorders may very well overlap. Debate continues about whether these categories should be discrete as the APA works toward the publication of the *DSM-V* in 2013 (Moffit et al. 2008). For now, it appears the diagnoses will remain separate but there is a proposal to remove the exclusionary criteria for CD when diagnosing ODD (APA 2011).

Returning to Edgewood, the overlap between GGI labels and *DSM* symptoms leads to an interesting result when female residents engage in GGI: they produce a type of symptom-talk in which their language mimics a medicalized model of behavior. It is unlikely that these residents would describe themselves with such terms independently. Rather, in being initiated into the practice of GGI, these youth learn a new—and highly pejorative—vocabulary with which to

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adoption, experience with them since their publication has revealed, as expected, many instances in which the criteria were not entirely clear, or were even contradictory" (Mallett 2006:445-446). The criteria for Conduct Disorder were revised and "Oppositional Disorder" became "Oppositional Defiant Disorder," also with revised criteria.

describe their everyday actions. Ian Hacking's notion of "making up people" is relevant here,
offering us a way to think about how the labels applied in GGI contribute to the making of a
specific kind of female youth—one whose behaviors are indicative of clinically significant
conduct problems. This has meaningful effects. As Hacking describes, "Our spheres of
possibility, and hence our selves, are to some extent made up by our naming and what that
entails" (2002:113). So too does Goffman's work on stigma (1963) lead us to think about the
very real consequences of being associated with specific attributes. Goffman reminds us that
understanding stigma—an "attribute that is deeply discrediting"—requires a "language of
relationships" (1963:3); to be discredited or to be seen as discreditable is only possible because
individuals live within a wider social world and take up membership within particular groups.
With this in mind, the rest of the chapter demonstrates how GGI plays out in practice at
Edgewood and asserts that the potential impact of labeling youth metastasizes when female
residents at Edgewood take ownership of their meetings.

GUIDED GROUP INTERACTION IN PRACTICE

Moving away from the model Guided Group Interaction and the prescriptions for how it
should be run, we encounter the world of Edgewood and the multiple ways that GGI plays out on
an ongoing basis. As far as I could gather during my time on the campus, the only regulation
governing GGI is that it be held twice a week in each cottage; what time of day it is held, in what
room of the cottage it takes place, where residents sit, the problems residents label, and the
involvement of the staff all differ markedly across cottages. With such flexibility, GGI is best
understood as being guided by distinct strategies of practice, some of which are dictated by staff
and others that are shaped by residents with specific end goals in mind. Below, I describe how
GGI works in two cottages—Hamilton and Thayer—in order to demonstrate that the structure

and content of GGI meetings is determined far more by the individual personalities involved than by the textbook model. I then turn to the strategies of practice employed by residents to co-opt GGI meetings and make them their own. This, in turn, allows one to understand how GGI can be marked by moments of helping as well as by moments where the boundaries of confrontation are quickly exceeded.

"You've Gotta Give Respect to Receive Respect"

To the extent that there is any cottage at Edgewood running a GGI similar to the original model, it is surely Hamilton Cottage. The cottage manager of Hamilton, Ms. Austin, is a middle-aged African American woman who has worked in child care for her entire career. A particularly devout Christian, she is the unquestionable authority figure in the cottage, alternately feared and admired by residents in her care. Like everything else she organizes for the cottage, Ms. Austin takes GGI very seriously: meetings are held every Tuesday and Thursday immediately after school gets out, all residents must be in attendance and sit in a designated seat, and the meetings are ritual-like in their consistency.

Each GGI in Hamilton starts when all girls are seated in a circle in the living room and Ms. Austin stands up. This prompts all the girls to stand up as well. At Ms. Austin's command, all residents repeat in unison: "you've gotta give respect to receive respect." This mantra must be said with clarity and conviction or Ms. Austin will ask the residents to start over; I was part of multiple meetings where residents were asked to repeat the saying because someone wasn't paying attention or was chewing gum, for example. At this point, all girls sit down and the meeting begins. Rather than starting immediately with problem-labeling, Ms. Austin asks each girl in the cottage to recite her ABS (Alternative Behavior Strategies). The ABS sheet is completed by each resident upon arrival to the campus and includes individual responses to the

following: (1) Resident's strengths and positive behaviors; (2) Triggers that begin stress

reactions for the resident; (3) How the resident knows when she has been triggered; (4) Negative

behaviors the resident has done in the past when triggered; and (5) Things the resident will do to

avoid negative behaviors when triggered. As a behavior management strategy, ABS are intended

to make residents aware of things that trigger them and more conscious of how they react to

stressful situations, and to encourage residents to think about positive coping strategies.[5] It is

unclear, however, whether such a purpose is ever achieved in GGI because of the way residents

undermine the process. Residents learn to repeat their ABS from memory and eventually get to a

point where they say them so fast that individual words become indecipherable. To an observer

in GGI, this part of the meeting was often comedic in its predictability. No one ever asked the

residents to slow down and only rarely did Ms. Austin ask the girls to reflect on whether they

were "using [their] ABS." The only interruptions during this portion of the meeting came from

Ms. Lewis, the Senior Child Care Worker whose role it was to keep notes of the meetings, and

who would tell residents when they said something incorrect or forgot part of their ABS.

Once all residents have recited their ABS, GGI continues. Residents set expectations or

"GGI Norms" for the meeting—"no arguing," and "no side conversations," for example.[6]

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5. The creation of an ABS sheet that identifies "triggers" and spells out appropriate ways to cope with them resonates with techniques used in cognitive behavior therapy (CBT), an action-oriented treatment approach to mental disorders. There is no single approach to CBT but techniques are modeled on the premise that cognition and behavior are linked in a two-way relationship and includes methods to identify patterns in thinking and learn strategies to revise them (Wright 2006).

6. I did see an 'official' list of "GGI Norms" typed up and distributed during one meeting in Thayer Cottage. It included the following: (1) Raise hand to be acknowledged; (2) No arguing; (3) No fighting; (4) No payback/revenge; (5) Attendance is mandatory; (6) No [head] scarves; (7) Must have something on your feet at all times; (8) No eating/chewing gum; (9) No side conversations (10) Must be on time; (11) No obsessive feedback; (12) Respect peers/staff and self; and (13) Be helpful not hurtful. Two of these deserve additional explanation. First, the ban on scarves is likely because they are often seen as a sign of confrontation; girls wear headscarves when they intend to fight because it will protect their hair from being pulled out. Second, "no obsessive feedback," likely indicates "no excessive feedback" here. From my observations, I note that residents add their own expectations to this list frequently, including expectations such as "no cursing," "accept criticism," and "one mic" (i.e., one microphone/one person speaking at a time).

Traditional problem labeling then begins. A resident labels herself using the language, "Since the last GGI, I've been inconsiderate to my peers and self for… [list of problems]." The peer group then has the opportunity to label that resident as well. A resident can respond to peer labels by saying, "I accept," or "I do not accept." She might also say, "Display," asking a peer to give her a specific example of when she engaged in that behavior. Once a resident has chosen to accept or not, there is no further discussion of that label. If a resident states that she "do[es] not accept," her peers are not supposed to pressure her further to accept.

Problem labeling is followed by "awarding" the meeting to a person or an issue and then speaking to that person or issue. Each girl suggests to whom or what she thinks the meeting should be awarded. It is Ms. Austin who makes the final decision, however. Often, Ms. Austin allows residents to address the person or issue they each suggested in the first place. Thus, multiple individuals and topics might be addressed in a single meeting. In the 24 meetings I attended in Hamilton Cottage, there were nine times when residents were allowed to speak about what they suggested individually (usually themselves or another peer), another nine times when they were asked to address a specific peer, three times when they were told to speak about their own behavior, and three times when they were asked to speak about a specific topic (physical aggression; lying and stealing; and abusing other residents' prescription medication). In cases where a specific resident is awarded the meeting, that resident will address the group first and her peers will then offer advice. The exchange below offers an example of how this might proceed. One resident, Latoya, addresses the fact that she got into a physical fight with another resident on the campus; this is followed by some sample responses from her peers.

Latoya: I have to act my age, be a role model, get on track, control my anger, not put my hands on other people's kids.

Tanya: Latoya, you gotta calm your anger down. We were all embarrassed.

> *Cynthia*: Latoya, you gotta live with these people… I look up to you as a role model so when you do bad it sets me back.
>
> *Tiffany:* Latoya, you can be a real hypocrite. Off something so stupid… you lost a friend. If you had never said nothing, nothing would have happened… you preach but you don't live.

As with all other GGIs, this meeting ended after every girl had been given a chance to address Latoya. It is important to note that staff facilitating the meetings at Edgewood intervene frequently to address and label residents as well. Even though Vorrath and Brendtro (2007:81) note that leaders should make few interruptions in a well-established group, it is regular practice at Edgewood for staff to speak throughout the meeting.

"It's Just GGI, So Who Cares?"

Having seen generally what GGI looks like in Hamilton Cottage, it is now possible to juxtapose these practices to those in Thayer Cottage. The point is not to evaluate the different GGI sessions but to show how the structure of GGI very much depends on the staff and residents participating and how different cottage dynamics lead residents to label unique problems and utilize alternate strategies of practice. Thayer Cottage is managed by an African American woman in her mid–40s, Ms. Williams, who has worked at Edgewood for four years and in the child-care field for approximately six years. Unlike her counterpart in Hamilton, Ms. Williams is relatively laid back and prefers to relate to her residents in a relaxed and friendly manner. Ms. Williams also relies heavily on her Senior Cottage Worker, Ms. Miller, who has been working at Edgewood for 18 years. Ms. Miller facilitates GGI meetings and, arguably, the two women share authority in the cottage equally.

The manner in which GGI meetings are scheduled and run in Thayer Cottage reflects its less structured environment. During my fieldwork, the time and day of GGI was changed

frequently, making it difficult for me to attend as many meetings as I did in Hamilton. Residents in Thayer are encouraged to have afterschool jobs on the campus and this means that GGI is generally held in the evenings. Because residents come back from their jobs at different times, however, meetings often get postponed or residents forget about the meetings and miss them entirely. In my experience, the consequences of missing GGI in Thayer were negligible and the general attitude from residents about the meeting was that it was of little importance. As one resident told a girl who had forgotten about GGI, "it's just GGI, so who cares."

GGI is also much less formal in Thayer Cottage than it is in Hamilton. Residents do not recite their ABS at the beginning of the meeting but start immediately with setting expectations. Problem labeling then starts and it is not infrequent that multiple residents will say they have "no issues to report" without any confrontation from their peers. In many of the meetings I attended, residents and staff became side-tracked by a particular issue during the problem-labeling portion of the meeting and never got the stage of GGI where the meeting was to be "awarded." Extended discussion about specific residents would develop side-by-side with problem-labeling and few attempts were made to refocus the meeting. In one GGI, for example, one resident labeled another as having a "self-monitoring problem" because "she is always in everyone else's business." When this resident did not accept the label, Ms. Williams surveyed the rest of the group on this issue rather than moving on, asking if anyone else agreed that the resident had a "self-monitoring problem." Several hands shot up in the air but the resident continued to say, "do not accept"; conversation then got stuck on this one topic. When meetings were awarded to individual residents or topics in Thayer Cottage, there was no format for how they should be addressed. That is, anyone could speak at any time. What resulted in many cases is that certain residents spoke frequently during GGI while other residents did not speak at all.

That residents in Thayer became accustomed to their more relaxed version of GGI—and were resistant to any attempts to change it—became clear to me one evening when Ms. Williams and Ms. Miller tried to reorganize the meetings. Ms. Miller began the meeting by asking all the girls to stand up and switch seats so that they were sitting next to someone new. This was met with immediate resistance. "I've been sitting in the same place for a whole year," Jasmine argued. "I'm not moving." Jasmine stood in the foyer of the cottage and refused to be part of the meeting for several minutes before finally joining—and returning to the same seat. Ms. Williams then passed out the list of "GGI Norms" (see footnote 6) to remind girls of the rules of the meeting. As soon as problem labeling started, however, residents began to violate rules with little regard to disrupting the flow of the meeting. Several girls talked at once, others were having side conversations, and one resident started falling asleep in the corner, prompting one of her peers to wake her up and mouth silently, "did you smoke [marijuana]?" The resident replied she had not smoked and closed her eyes again. Whatever intentions Ms. Williams and Ms. Miller had for that specific GGI appeared to be abandoned. At the end of problem labeling Ms. Miller noted that they "hadn't really even started GGI" because the group was supposed to award the meeting to a single person or issue. She raised the issue of completing chores but the meeting quickly turned into a discussion about how one resident took too long in the shower and got soap everywhere. Neither Ms. Williams nor Ms. Miller redirected the meeting and it ended shortly thereafter.

It is worth noting that GGI meetings in Thayer Cottage—apart from being a source of anxiety for me because so many people talked at once (making note-taking difficult) and because confrontations often escalated—were also a source of frustration to Ms. Miller. Although Ms. Miller endorsed GGI as a way to "have students voice their opinions and what issues they're having and what their needs are," she also admitted that she didn't "think it's being used today as

it should." For one thing, she thought that there were "too many people involved in the meeting." She added further, "whoever is assigned to run the meeting needs to be able to run an effective meeting where the students get results, because the meeting is for the students, not the staff" (Interview, November 3, 2010). Given other conversations with Ms. Miller throughout my fieldwork, it is reasonable to conclude that this comment indicated frustration with other staff members in the cottage, who would interrupt meetings or derail the agenda altogether (there are generally three to four staff working in one cottage for each shift), rather than any pointed frustration about how residents participated in the meetings.

"Since the Last GGI…"

Having outlined how GGI works in two different cottages on Edgewood, I turn now to examine the most common types of problems that residents label during GGI meetings. One of the most remarkable things about GGI at Edgewood is the way that residents expand the parameters of problem-labeling to include whatever problems they think are important to address; this list goes well beyond the original 12 labels developed in the GGI model. By taking notes of what residents said at every meeting and tabulating these data, I counted 147 unique labels that residents used in GGI meetings during my fieldwork (See Appendix F for a full list of labels). These labels can be grouped thematically into nine areas: (1) Problems related to campus life (e.g., AWOLing, going out of program, poor school citizenship/cutting class); (2) Emotional and attitudinal problems (e.g., easily angered, having an attitude, being defiant); (3) Problems related to one's sense of self (e.g., having low self-esteem, letting people get to you, not respecting yourself); (4) Problems with negative activity (e.g., being part of the problem, engaging in negativity, not making better decisions); (5) Problems with fighting and arguing (e.g., starting trouble, instigating peers, threatening people); (6) Problems with peer and staff

relationships (e.g., disrespecting peers or staff, inconsiderate to peers, reaction to authority); (7) Problems with progress (e.g., falling off track, no change no growth, not caring); (8) Problems with sexual activity and substance abuse (e.g., smoking, drinking, sexually acting out[7]); and (9) Miscellaneous problems (e.g., cursing, gossiping, not acting your age). In addition to these eight broad categories, residents can choose to say they have "no issues to report."

Given that the meetings in each cottage are unique, it is perhaps not surprising that the problems residents label in each cottage also differ. Table 7 below shows the most common labels listed in GGI for each cottage and breaks down responses by the number of times a resident gave herself a particular label versus the number of times a resident was assigned that label by peers (across all GGI meetings I attended). The number in parenthesis indicates the rank of that label within the cottage among all 147 possible labels; a rank of 1 indicates that it was the most frequent label stated whereas a rank of 2 indicates that it is the 2nd most frequent label. The ranking is helpful because the numbers in Hamilton look substantially higher than the numbers in Thayer as a result of the fact that I attended 24 meetings in Hamilton and only seven in Thayer.

Table 7 Frequency of GGI Labels in Hamilton and Thayer Cottages

Label	Hamilton		Thayer	
	Self-Labeled	Peer-Labeled	Self-Labeled	Peer-Labeled
Easily Angered	89 (1)	37 (3)	17 (3)	5 (5)
Cursing	71 (2)	23 (4)	14 (4)	2 (12)
Attitude	64 (3)	49 (2)	2 (13)	0 (25)
No change, no growth	49 (4)	72 (1)	3 (12)	4 (6)
Going out of program	38 (5)	10 (20)	10 (7)	0 (25)
Falling off track	6 (32)	22 (5)	0 (23)	0 (25)
No issues to report	13 (14)	0 (127)	20 (1)	0 (25)
Poor school citizenship	12 (17)	1 (82)	20 (1)	8 (3)
Reaction to authority	0 (107)	0 (127)	14 (4)	3 (9)
Inconsiderate to peers and self	12 (17)	17 (6)	5 (9)	11 (1)
Hygiene (personal & room care)	9 (25)	15 (8)	2 (13)	9 (2)
Substance Abuse problem	1 (73)	1 (127)	4 (10)	6 (4)

7. To label someone as "sexually acting out" is to suggest that a resident is being *too* public with her sexuality or gaining a reputation for promiscuity. Residents are not commenting on the fact of sexual activity but, rather, the degree and visibility of that activity.

A few things are worth noting when the cottages are compared. First, the range of labels used by residents varies by cottage. Whereas there were 144 labels used by residents in Hamilton, residents in Thayer Cottage used only 34 labels in their meetings. While it is true I attended more meetings in Hamilton (24, versus seven in Thayer), allowing for more opportunities to hear various labels emerge, the difference remains a large one. Furthermore, residents in each cottage appear to use unique labels. In Hamilton, it is common to label someone as "falling off track" but this label was never used in Thayer. Conversely, in Thayer, residents label each other for having a "reaction to authority"; this label never surfaced in Hamilton.

Second, the ranking of particular labels is cottage-dependent. Whereas the number one label residents give themselves in Hamilton is "easily angered," the number one label in Thayer is a tie between "no issues to report" and "poor school citizenship." It is surprising that "no issues to report" was the most frequently used label in Thayer when the whole purpose of GGI is to label problems. Thayer residents rarely confront one another, however, so it is relatively easy to indicate that one has "no issues to report" without fear of being perceived as disingenuous. By contrast, it is nearly impossible for a resident in Hamilton to claim she has "no issues to report" because Ms. Austin or the peer group will immediately label the resident instead. The fact that Hamilton residents most often gave peers the all-encompassing label of "no change, no growth" makes it hard to imagine the Hamilton resident who would have been able to slide under the radar with "no issues to report."

Strategies of Practice

Having examined how labels are used within individual GGI meetings, I turn now to describe some of the broader tendencies that emerged during my participation in multiple GGI meetings. I call these tendencies "strategies of practice" because I want to connote how residents

employ them intentionally, and with particular thought to the outcomes they would like to achieve in the meeting. Through these strategies of practice, Edgewood residents are able to orchestrate GGI meetings from behind the scenes, sometimes making confrontation appear staged or performed.

The first strategy used by some residents at Edgewood is to create a list *prior to* GGI that includes all of the behaviors they think they need to label for that meeting. Once inside the meeting, the resident is then able to read all behaviors directly from the list, which is often very long. While it may seem counterintuitive for a resident to actively give herself multiple labels— and thereby highlight all the problem behaviors in which she has engaged—this strategy often works to preempt further labeling by peers. By the time a resident gets through her own list, the peer group may have nothing else to say, thereby allowing the resident to avoid confrontation by her peers. One Hamilton resident, Clarice, was a master of this strategy, as an excerpt from my field notes details: "I wrote furiously to capture everything Clarice was labeling—'fighting, easily angered, caring what people say, no change no growth, inconsiderate to peers, not caring about myself, thinking about too much'—before falling behind and just listening to the rest of her list. She mentioned at least 15 additional labels. No one else in the group confronted her."

Understandably, being confronted is a source of anxiety for many residents, particularly when they are new to the campus. As one resident told me during an interview, "When I first got here… every time when it was GGI, I used to always be scared. I used to have, like, butterflies in my stomach when GGI come. 'Cause you never know what somebody realize that you don't realize. You never know what somebody gonna bring up about you that you don't know." This resident was forthcoming about her strategy for dealing with such anxiety: "If I didn't have an issue, I used to just say something because I had to be nervous that somebody else was gonna say

something. So I just used to say something for myself so I could be over with it" (Interview, September 23, 2010).

A second strategy that residents use in GGI is to think collaboratively with their peers prior to an upcoming meeting about what they will label for themselves or their peers. I observed this practice frequently when sitting with girls in the cottage living room before GGI began. The following exchange is emblematic:

Latoya: You should label yourself easily angered.

Maria: I got you. What are you going to label?

This type of dialogue between peers is similar to the first strategy in that it may be a proactive way to avoid being confronted by peers in the larger GGI meeting. But it is also a way for residents to jointly anticipate what will be said about them and to suggest labels that will go over well with the rest of the group. In the example above, Latoya may be telling Maria that she is actually "easily angered," or she may simply be jogging Maria's memory about the range of acceptable labels.

A third strategy seen in GGI is for a resident to "accept" most or all of the labels assigned to her by her peers. A resident may say, "I accept," to a label—oftentimes, even if she does not believe it—because it is a way for her to avoid escalating arguments in the cottage. When speaking to a new resident about how GGI worked, for example, a long-time resident of Edgewood remarked, "It will make your time easier if you just accept criticism… just accept everything." Passively accepting all criticisms becomes a way for residents both to seem remorseful and to maintain peer relationships.

The alternative to accepting peer labels is for a resident to indicate that she has "no issues to report" and/or to respond with, "I don't accept," for any label given to her by peers. When a

resident reports that she has "no issues to report," she may have had particularly good behavior since the previous meeting or she may be trying to slip under the radar (though she still risks being labeled by her peers). When a resident states that she "does not accept" a problem however, she knows that conversation is supposed to end on the label—she is not supposed to be pressured to change her mind. Theoretically, then, a resident can continuously say, "I don't accept," to every problem her peers mention and there is no real resort for the group.

Of course, the problem of such a strategy is that one runs the risk of incensing the peer group by denying any problem behaviors. This may result in additional peer pressure to accept the label: "Don't you get tired of hearing other people's mouths?" or "A lot of people can't be saying the sky's blue and you the only one saying it's not true," are examples of reactions that individual residents received when trying to claim they had "no issues." The peer group may also respond to repeated denials from a resident by giving the resident an additional label of "no change, no growth." Such was the case in Thayer Cottage one night when Ali would not accept a number of peer labels in a row. Another resident, Natasha, got frustrated that she would not accept the problems being listed and so kept conjuring another problem to label for Ali, to which Ali continued to respond, "I don't accept." Finally, Natasha said, "Fine, then no change, no growth" and Ali accepted the label. Turning to the group, Natasha reflected, "Good. 'Cause you know I was going to keep going until she accepted *something*." Such an exchange demonstrates how, for the most part, it is not possible to escape criticism in GGI.

The pattern of peer pressure exemplified by Natasha is identified in the GGI literature as something that can lead to "problem trivialization." From interviews with youth in ten different peer group programs for troubled adolescents, Brendtro and Ness (1982) found that "youth felt the emphasis on problems sometimes became obsessive, causing groups to 'identify' problems

that do not exist, and which then must be the topic for group discussion." They give an example of a youth who overlooked a cup while setting the dinner table and was then identified by the group as being "inconsiderate of others." "The youth who did not fully set the table was 'given' a problem by the group; he denied it, and the group became bogged down attempting to pressure the youth to admit ownership of the problem" (1982:320). Indeed, when the peer group wants someone to accept a problem, they may continue to raise insignificant issues in the attempt to wear the resident down.

A final strategy exploited in GGI, and one that occurs after problem-labeling has ended, is for a resident to indicate that she would like the GGI meeting awarded to herself. Several explanations may account for this phenomenon. First, a resident may award the meeting to herself because she genuinely wants feedback from her peers about how she might work on her problems; as explained below, the peer group can be a source of motivation and encouragement in particular situations. Second, a resident may choose to award herself the meeting as a way to signal at least partial responsibility for her behaviors. This may be because she hopes that the staff member awards the entire meeting to her, or alternatively, because she hopes the staff awards it to someone else but simultaneously acknowledges that she is taking ownership of her behavior. Finally, it is possible that a resident awards a meeting to herself as a way to avoid addressing her peers' issues. If granted, the resident finds a convenient way to avoid confrontation with the peer group.

Taken together, the strategies that residents use in GGI say much about the extent to which they actively resist buying into a peer intervention based on confrontation. In a place where relationships are already fractious and temporary, it is understandable that residents do not want to engage in a process they see as fundamentally critical, rather than positive. As one

resident reflected, "I don't like when people say things about me. I take stuff to the heart, but I be trying to keep my cool in there... [so] I don't really label nobody like that" (Interview, October 14, 2010). This is a practical orientation given that residents live in cottages with up to 20 girls for months at a time. Residents become strategic manipulators of GGI meetings in order to preserve their own sense of self as well as their relationships with their peers. Below, I demonstrate how, in taking ownership of meetings, residents can steer GGI in both positive and negative directions.

THE EFFICACY OF GUIDED GROUP INTERACTION

Helping Peers

Insofar as the strategies revealed above demonstrate multiple ways for residents to avoid confrontation during GGI, it is important to note that peers continue to label each other regularly and that several residents find being called to task by their peers as something helpful, if not anxiety-provoking. As one resident told me, "I think GGI's really helpful. It helps me. When the residents… confront me, I feel so much better… If I think about it, it's true what they be saying and I try to change it, work on it" (Interview, July 24, 2010). Other residents likewise note the potential for peer confrontation to serve as an opportunity for growth, reflecting that "it helps you grow" and "if she says that and she says that, then I have to fix it" (Interviews, August 18, 2010 and September 22, 2010).

It is when meetings are finally awarded to a particular individual that the opportunity for peers to help one another is most apparent and the potential for GGI to serve as a therapeutic intervention is realized. Over the course of my fieldwork, I wrote often about the thoughtful advice residents shared with their peers inside the GGI circle. Time after time, girls who had just levied a litany of criticisms on one another would reframe their thinking and give the same peers

advice. In Hamilton Cottage, where this part of the meeting was often lengthy, such advice almost always came in the form of encouraging peers to "get back on track." Envisioning their problem behaviors as examples of "falling off track," residents likewise held that the fix for such behaviors was to climb back on track. Apart from being a common metaphor, the idea of "getting back on track" has been noted in literature on adolescent resilience as a common way that youth describe their ongoing efforts to wrestle with challenges (Smokowski et al. 1999:435). The image suggests that even as Edgewood residents come up against multiple problems in living, they help each other avoid defeat; the "track" is always near them.

The advice exchanged in GGI is not merely strategic or instrumental, however. Two examples from my fieldwork demonstrate the degree to which GGI provides space for compassion. The first provides an example of peers responding to a resident who has recently engaged in self-injurious behavior (cutting her arms) whereas the second shows how peers react to a resident who has disrupted cottage life considerably by doing drugs, being promiscuous, and going AWOL. The two examples are used as counterpoints to show how advice may be offered whether the problem behavior is directed at the self or the group.

On a snowy afternoon in Hamilton Cottage six weeks into my fieldwork, GGI was awarded to Keshanna after she had been found with fresh scabs on her arms from intentionally cutting herself with scissors. Most girls in the circle suggested that the meeting be awarded to Keshanna, but it was Ms. Austin who made the final decision along with a dark comment: "If you end up in the hospital, Keshanna, people will think you're crazy. Look at the kids in Haiti, and you don't see anyone cutting themselves" (this was soon after earthquakes destroyed much of Haiti). Sitting on the stairway listening to the meeting, I feared that such comments from Ms. Austin might steer the meeting in a certain direction, with residents parroting a common

sentiment articulated by staff—that residents at Edgewood don't have "real" worries because they have a roof over their heads, a bed to sleep in, and three meals a day. I winced at the false comparison Ms. Austin was drawing between Keshanna's situation as a 15-year-old who has been in foster care for most of her life and the plight of earthquake survivors in Haiti.

Rather than following Ms. Austin, however, residents in Hamilton came to Keshanna's side on this afternoon and empathized with her. Four of the 12 additional residents in the meeting that day shared their own histories of cutting themselves, telling Keshanna that the cutting had not resolved their problems and that the physical scars still remained, making them feel even worse about themselves.[8] Latoya, for example, reflected, "Keshanna, I did this when I was like 12 and now I'm 16 and it's not going away… cutting yourself for no reason because the problem is not going away… I was mad [at you], like, why did you do that?" Others reminded Keshanna that people at Edgewood cared about her: "Someone cares about you," said one. "People really do care," remarked another. Still others urged Keshanna to "try to find someone to talk to." Keshanna, ever honest with her emotions, floundered to think of how to address her own issue, saying "I got nothing" when first asked to speak about the behavior and then finally admitting that while she knew she should not cut herself, the best she could offer right now was to "*try* not to cut myself." I don't know whether Keshanna was buoyed by her peers but to my knowledge she did not cut herself again for the next five months (another incident occurred in July).

In a markedly different example of peers helping one another, a separate GGI session was awarded to Selena during one afternoon in late April 2010. At the time of the meeting, Selena

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8. Researchers have taken an increased interest in self-injurious behaviors that do not appear to include suicidal intent, as was the case with Keshanna. In addition to capturing the attention of the popular media (Kluger 2005), nonsuicidal self-injurious behaviors (NSSI) are thought to be increasing in frequency. The prevalence of NSSI is high among adolescents especially (12-21 percent in community samples and 21-61 percent in clinically-referred samples) (Prinstein et al. 2010). Studies also indicate that girls are significantly more likely than boys to engage in these self-injurious practices (Ross and Heath 2002). For an anthropological perspective, see Lester (2011).

had been struggling with the Edgewood program for several months. She resented the strict

supervision and control on the campus and came head to head with Ms. Austin frequently. Most

recently, Selena had been caught sleeping in her boyfriend's cottage in the middle of the night

and had gone AWOL with her boyfriend on three separate occasions. She was also smoking

marijuana regularly. The girls in Hamilton Cottage were angry with Selena for her behavior

largely because they thought it reflected badly on the entire group. With boys walking around on

the campus saying that Selena was "burning" (i.e., that she had a sexually transmitted disease),

more than a few of Selena's peers articulated their sense that Hamilton was "getting a reputation

as a cottage with a lot of 'hos." The girls in Hamilton Cottage spoke frequently about how they

had a better reputation on campus than the girls in Thayer Cottage, so the fact that Selena was

tarnishing this reputation was no small matter.

Despite the longstanding enmity toward Selena about what was understood as negative

publicity for Hamilton Cottage, for the most part Selena's peers rallied around her in this

particular meeting. Even as they admonished Selena for her behavior, they likewise tried to

express that they cared about her and that she deserved more than a boyfriend who they

perceived was using her for sex. Latoya addressed Selena at length:

> I think that Selena, I've been feeling mad [i.e., very] bad but you put yourself out there in
> a bad way… it's sad, these boys don't care about you… your body is a temple… you
> have time to change. You should practice abstinence and save yourself for your
> husband… I think you need to pray… you lied to me and I wanted to punch you in your
> face… you know what they think about you?

Other peers reminded Selena that they could help her change and that they were willing to talk to

her. "I'm not the most positive person in the cottage," reflected Cynthia, "but I can help you. I

see a change in myself and you can change." Selena promised them that their advice would "not

be a waste of time" and that she would work harder at respecting herself.

Moving Beyond Confrontation

Even though there were clear moments throughout my research when GGI worked to support and encourage residents at Edgewood, meetings just as easily became a place of unbridled criticism and a forum where peer confrontation chipped away at the already compromised self-esteem many of these girls possess. Much of this was due to the fact that residents were asked to speak about things they were uncomfortable sharing with the whole group. Reflecting on this after one particularly personal GGI session, a resident in Thayer Cottage noted that she felt bad for her roommate, who had been forced to talk about why her mother never came to visit: "that was uncomfortable for her to talk about with mad [i.e., many] people. That's her personal business" (Interview, September 23, 2010). Indeed, there were several times when residents and staff misused confrontation, making it a hostile process and forcing self-disclosure. This is not unique to Edgewood. Brendtro and Ness's interviews with staff using peer group interventions cited "abuse of confrontation" as the number one concern raised by staff (1982:311); Kapp's more recent work offers evidence that "constantly being 'at odds' with their peers was harmful from the participants' point of view, especially when the model invited intense personal evaluation from all group members" (2000:183)

The "abuse of confrontation" also created a situation where peers would "give advice" to peers on topics about which they knew relatively little and were not in a position to do anything about. An example from a GGI awarded to Aisha in Thayer Cottage illustrates this well. Aisha was well known at Edgewood for what was commonly referred to as "running her own program." Having been voluntarily placed into foster care by her mother, Aisha returned home often, leaving the campus for days and sometimes weeks at a time. When she was on campus, Aisha was almost always high on marijuana and skipped most of her classes at school. She was

also known for her explosive anger, throwing things in the cottage if told she could not use the telephone and frequently getting in fights with other residents on the campus. Nonetheless, Aisha was generally well-regarded by her peers for her candidness and her sense of humor. During one evening GGI in Thayer, Aisha's peers awarded the meeting to her because of a recent fight in school. When justifying why Aisha should get the meeting, the residents were harsh: "she's reckless," "she's crazy," "something is wrong with her," "she's always instigating," "730[9]."

Aisha was asked to speak first about the problems she was having. She spoke with clear resignation: "I have 'Aisha problems' that you can't help with… This isn't the fucking place for me. Everybody keeps saying she [her mother] should sign me out but you don't understand she don't want me." At this point, another resident in the cottage said that Aisha should start caring about her behavior in order to show her mom she was capable of being good and living at home. Aisha had an answer for this too, however. "The funny thing is," Aisha said, "I don't even want to go with her." Comments to Aisha now took a different route. Girls started telling Aisha that she didn't have to go with her mother if she didn't want to and that she had legal rights. "You have a voice," someone said. The girls barely allowed Aisha room to speak, arguing about her best options even as she was telling them that her mother refused to give up her parental rights. "What do you think I have been trying to do for the last year?" Aisha finally asked the group with exasperation, signaling that she had already been thinking about her options and that the group's suggestions were both outdated and unhelpful. The conversation came to a close when Aisha concluded that if the adults overseeing her case (her mother and social workers) were going to "make her miserable," then she was going to "make everyone miserable too." "I'm

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9. Article 730 of New York State Criminal Procedure Law dictates the procedures for adjudicating someone as an "incapacitated person" by virtue of "mental disease or defect" and thereby declaring them unfit to stand trial. The number 730 has been adopted in slang to mean "crazy" (Urban Dictionary 2011).

going to tweak on you bitch," Aisha threatened, the "you" being no one specifically and everyone in sight at the same time.

As Aisha's case makes clear, it is relatively easy within the space of GGI for conversations to exceed the boundaries of the intervention. Because residents take ownership of their meetings, they can steer them beyond the intended scope of confrontation quickly. What starts as labeling a peer and awarding a meeting in order to provide helpful advice, readily becomes an arena for dissecting the intimate details of individuals lives and relationships, with little staff intervention to steer the meeting in another direction. This occurs on top of the already harsh criticism that residents receive in the labeling phase of the meeting. While residents are often resilient in brushing off this criticism, choosing to ignore their peers or actively deny specific labels, the impact of what is essentially name-calling may last longer. Indeed, it is well worth considering whether there is a saturation point within GGI. At what point does helpful questioning and advice become an intrusive and wounding inquisition?

Guided Group Interaction As Confession

To suggest that GGI might alternatively be thought of as an "inquisition" of sorts is deliberate on my part, intended to invoke the aspects of GGI that bring it into alignment with forms of religious confession. This is not to say that GGI is overtly religious at Edgewood. To the contrary, apart from Ms. Austin's personal religious convictions that would sometimes find their way into GGI in the form of aphorisms ("preach and practice"), faith and spirituality were never discussed inside the GGI meetings during my fieldwork. At the same time, GGI often felt like a confessional, a space where residents at Edgewood were asked to reveal their weekly sins as a path to self-improvement and redemption. Here, I consider this line of thought with the help of Michel Foucault's work on the hermeneutics of the self.

Foucault's two lectures, "Subjectivity and Truth," and "Christianity and Confession," trace the genealogy of the self, meditating on issues of individuality, discourse, truth and coercion, and hinting at some of the themes that would occupy Foucault's later work in the second and third volumes of *The History of Sexuality*. Foucault articulates at the beginning of his first lecture that he is concerned with a common postulate in the Western world—"that one needs for his own salvation to know as exactly as possible who he is and also… that he needs to tell it as explicitly as possible to some other people" (1993:201). He writes: "to declare aloud and intelligibly the truth about oneself—I mean, to confess—has in the Western world been considered for a long time either as a condition for redemption for one's sins or as an essential item in the condemnation of guilty" (Foucault 1993:201). Foucault anchors the concern for knowing oneself in a long historical narrative, showing how it is woven into various periods, from the Delphic precept of *gnothi seauton* ("know yourself") to the monastic precept of confession, to the existentialism coming out of World War II's chaos. It is the transition from the Classical period to early Christianity, however, that Foucault identifies as the fundamental transformation in what he calls the "modern hermeneutics of the self"—that is, the process of self-examination (1993:211).

Foucault suggests that a distinguishing mark of Christianity is the obligation imposed on every Christian to manifest the truth about oneself. Historically, this obligation was not always carried out in the form of the confession. In the first centuries of Christianity, truth was deeply connected to penance but penance was a status rather than a single act; the penitent had to reveal their suffering and shame over time to obtain reconciliation (Foucault 1993:214). Meanwhile, beginning in the earliest monastic institutions and continuing to the present day, the principles of obedience and contemplation led to a very different type of self-examination. Here, the verbal act

of confession makes the truth appear; the presence of someone to hear this confession is necessary because that person listens as the proxy of God. Foucault notes that this verbalization of thought is required to be ongoing—"permanent, exhaustive, and sacrificial" (1993:220).

The centrality of ongoing narration to the act of religious confession reappears quite clearly in therapeutic environments also premised on the recovery of the individual through self-knowledge. Psychoanalysis, of course, is based largely on discovering one's inner self through talk. As Rieff suggests in his work on Sigmund Freud, Freud's method of treatment had an "emancipative intent." "Talk is therapeutic in itself… talk—language—is the essential medium of consciousness, and therefore the essential means of liberation" (Rieff 1979:335). It was not enough, however, to merely express one's emotions in Freud's framework; one must also analyze them. "More permanently curative than to evacuate an emotion would be to understand it; for the patient gained control not through the emptying but through the understanding of emotion" (Rieff 1979:348). Freud's psychological man is thus one whose insight ultimately leads to self-mastery.

If Freud's psychoanalysis is based on a private therapeutic encounter between the patient and his analyst, other therapeutic environments require a more public spectacle. Young's (1995) ethnography of clinical practices at a center for war veterans diagnosed with Posttraumatic Stress Disorder (PTSD) demonstrates how clinicians regarded talking within group therapy as evidence of a patient's progress. In that therapeutic environment, recovery from PTSD was premised on the ability of the patient to recall his traumatic memory, disclose it during group therapy, and subject it to scrutiny (Young 1995:185). The fact that most patients eventually did provide "satisfactory" narratives of such trauma was taken to be proof of the center's therapeutic efficacy (even if the patients themselves did not feel they had achieved any catharsis); those patients who

resisted narrating an event were liable to be accused of "not working" by therapists and other patients (Young 1995:216). A similar reliance on a very public, self-disclosing talk is found in GGI, where labeling oneself and one's peers is intended to be transformative, and the failure to label oneself might garner an individual the label of "no change, no growth." GGI encourages youth to recognize problems with their values and behavior by disclosing them to the group. In fact, the model suggests that it is only by identifying and verbalizing one's problems that the individual can learn to conform.

The parallel between confession as permanent verbalization and the truth-telling that is encouraged in GGI becomes clearer through example. During one of my first days in the field, Ms. Austin held GGI as scheduled and awarded the meeting to discussing a recent discovery in the cottage: Keshanna was collecting psychotropic medications from residents and then selling them to other residents within the cottage. Ms. Austin went around to each girl seated in the circle and asked them individually if they had either taken the medication or known about other girls doing so. Of the 12 girls in the circle in addition to Keshanna, only one resident admitted to taking the medication. After repeated provocations from Ms. Austin to tell the truth, however, three additional girls admitted to taking some. Ms. Austin asked these girls why they had taken the medication. "I like the way it made me feel," said one. "I wanted my problems to go away… I wasn't thinking," said a second. Then, turning to the girls who had admitted to at least knowing about the incident, Ms. Austin asked why they had not told anyone. To this question, she received no responses. GGI was ended after a tense silence lingered.

To what extent do these confessional practices "work" then? In private religious confession, the very act of confessing is sufficient to absolve one's sins. The confessor offers the absolution blessing and the individual receives comfort that his confessed sins will not be judged

again. And within the practice of psychoanalysis—as envisioned by Freud—the patient gains insight by forging an interpersonal relationship with and listening to the interpretation of his analyst. Even if psychoanalysis is not intended to be permanently cathartic, it is at least designed to foster self-examination and understanding. Within GGI, however, confessing to taking prescription medication without permission does not create any desired transformation. Residents' transgressions are not forgiven nor do residents necessarily come to any understanding of their behavior that might serve as a catalyst for change. Ms. Austin forces confession among the girls in Hamilton but the purpose of such confession (to punish or, perhaps, to encourage self-reflection) is never elucidated and no effort is made to probe the underlying reasons why the residents may have wanted to "feel different" or "have [their] problems go away."

The insistence on confession in front of a larger peer group may, in fact, exacerbate levels of distress. In Young's work, for example, a patient criticizes his therapist after being pushed to say "something more": "Last time you said, 'Talk,' I talked. You opened me up like I was a wound. But you never closed me up. You left me like that… I came here to get better, but I'm going to leave worse off than when I came. You know how to open us up, but that's all" (1995:190). The visceral image of a wound left open resonates with moments in GGI where residents are asked to disclose information only to be left alone with that information, unprocessed. For GGI asks for truth-telling but it does not offer a forum for forgiveness or understanding that might lead to healing. Residents must return week after week to announce new problems, permanently introspective but never transformed.

CONCLUSION

In this chapter, I have shown that GGI diverges significantly in theory and practice. Far from following a single script, GGI at Edgewood is cottage-specific and very much depends on the creative adaptations of the staff and residents who participate. The flexibility of the model as practiced creates room for residents to develop strategies for molding GGI meetings toward specific ends. Some of these strategies work directly to undermine the intended purposes of GGI; residents find multiple ways to avoid peer confrontation altogether or are complicit in finding ways to make problem-labeling a relatively benign exercise.

In looking at how practice falls away from theory, this chapter has also demonstrated that there are real effects to labeling people within GGI. The type of youth that the model GGI imagines is one that is inherently delinquent and disordered, with the similarity between GGI labels and *DSM* symptoms suggesting uncomfortable assumptions about the youth who participate. The potential impact of labeling is compounded when we look at the virtually exhaustive list of labels that Edgewood residents have created for GGI. With 147 labels recorded in my fieldwork alone, every detail of one's behavior is subject to criticism and it becomes easy for GGI to move beyond its intended scope. Is it any wonder that youth are anxious about GGI?

The broader question raised by this chapter is about what type of person emerges within GGI. Residents are broken down in GGI with the expectation that they will eventually learn to change. But what type of self is built up instead? I have argued that GGI focuses on self-disclosure in ways that are not entirely dissimilar from forms of religious confession or classic psychoanalysis. In all of these cases, transformation is predicated on self-examination. Whereas religious confession may allow for absolution and whereas psychoanalysis promises insight if not catharsis, however, GGI offers no equivalent. Residents return to meetings week after week

with the expectation that they will have more problems to admit but with no one to face who can forgive their problem behavior or help them understand why they engaged in it. The popularity of the label "no change, no growth" is particularly telling, pointing to how often residents are told that they have been unsuccessful in transforming themselves.

This seemingly endless process of labeling and confession is not without interruption, however. In the next chapter, I examine a moment when the cycle is disrupted by residents and the normal GGI process breaks down. It is in the space of this breakdown that opportunities emerge for alternative versions of the self. Forged within an intervention whose theoretical model is based on labels that sound like *DSM* symptoms but whose practical expression diverges through the strategies residents adopt, these new selves are, perhaps ironically, closely aligned with psychiatry.

CHAPTER 5
DIAGNOSING PEERS AND SELF

This chapter continues the work of chapter 4 but shows how psychiatric selves emerge in GGI when conventional labeling practices no longer suffice as an explanation of behavior. The chapter is structured around a vignette from a GGI meeting that occurred several months into my fieldwork. Within this particular meeting, psychotropic medications and Bipolar Disorder become central, as staff and residents alike lay claim to a body of psychiatric knowledge. The vignette provides an opportunity for three lines of analysis. First, I assert that this vignette is especially noteworthy because it represents a moment of slippage in everyday descriptions of self. Like many teenagers, the residents of Hamilton and Thayer Cottages marginalize the salience of mental health problems in their lives regularly, making it all the more important to pay attention to those moments when such problems are brought to the forefront. Second, I show that attitudes about the efficacy of psychotropic medications are ambivalent—and at times contradictory—precisely because taking medication forces Edgewood residents to distinguish between a "real self" and a "medicated self" and to confront the possibility of psychiatric disorder. Finally, I consider what happens when youth themselves invoke a psychiatric label and how self-labeling shifts the ground of meaning for a larger group of peers. I argue that the Bipolar diagnosis functions both to forgive and discredit in this setting, allowing youth to purchase leniency from their peers but only at the cost of being perceived as somehow broken. As in the previous chapter, my overarching concern here is how different selves are made up within a nominally therapeutic environment and with what consequences.

"You Bipolar?!"

The scene below played out during a GGI meeting in Hamilton Cottage. Although Hamilton's Cottage Manager, Ms. Austin, facilitates GGI meetings on most occasions, Ms. Lewis, the Senior Child Care Worker, led this meeting. Reconstructed from my field notes, the conversation proceeded as follows:

"You need to stop playing and trying to be sneaky because it's not working out for you," Makayla said to Brianna.

Brianna had been caught lying to staff about having a relationship with another girl in the cottage and her peers had thus awarded the afternoon meeting to discussing her behavior. The other girls in the circle echoed Makayla's sentiments.

"Why do something when you know you're gonna get in trouble?" Amber said.

Brianna slumped down in her chair, waiting silently for each of the eight other girls in the circle to address her. There was exasperation in many of the voices; this was not the first time that Brianna had been awarded a meeting for lying.

Ms. Lewis finally interjected, asking Brianna directly if she and Tanya were in a relationship. Brianna said "No" again, evoking stifled laughter from the rest of the girls, who were in disbelief that Brianna would continue to lie about something so transparent. Ms. Lewis sat back with some resignation. "When I get ready to do my report on medical, I'm gonna ask them 'cause I don't think those medicines are working… It ain't working for her."

Amber responded that Brianna didn't need more medication. "She told us the other day that she take 1,000 mg of medication a day."

Ms. Lewis repeated herself: "Well it's sure not working… it's not working… cause she be up all night." Then, turning to Brianna, she asked, "Is it helping you?"

Brianna shook her head "no" and said softly, "I'm Bipolar."

"You Bipolar?" Amber asked with interest.

"You is?" Keshanna seconded.

"You Bipolar?" Clarice repeated.

"I never even knew that. I never even knew that," Keshanna reflected.

Amber then asked Brianna what medication she was taking and, when Brianna responded

that she was taking Depakote[1], Amber offered that the same medication had made her tired.

"So how come it ain't doing nothing for [Brianna]?" Ms. Lewis wanted to know.

Amber considered the question, then answered, "She way bigger than me. I don't know…

my body is small. She need more meds."

Ms. Lewis responded: "That's what I'm saying, I think she need more meds."

Keshanna was surprised by this. "More meds?" she asked. "Yo! How much? Like five

more pills? I think medication should be stopped because it really change people."

Ms. Lewis responded to Keshanna, "If medication stopped in here..."

"There would be hell!" Keshanna said with laughter.

"There won't be no staff," Ms. Lewis replied.

Another resident jumped in, "Staff need it too!"

"Yeah I think I need some," Ms. Lewis reflected. "I think I need some to come in here. I

do! I do! I think I do!"

Makayla was uncomfortable with Ms. Lewis' suggestion that Brianna take more

medication and she said so. "Ms. Lewis, I don't like that. I don't like when you say that because

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1. Depakote (generic: divalproex sodium) is an anticonvulsant medication used in the treatment of seizures, as well as in the treatment of acute mania associated with Bipolar Disorder. It is also used off-label for other conditions, particularly for other psychiatric conditions (such as Attention Deficit Hyperactivity Disorder). Drowsiness is a noted side-effect of the medication (PubMed Health 2011).

people don't need medication. Medication's a phase. Because you could take medication and still not be getting the help, like you don't have nobody to talk to, you still gonna be depressed, you still gonna be angry, you still gonna be sad. You could take a pill – wow! It's shooting in your body making you tired that's it. It's not calming you down. You know how many times I took my meds and still do things, or still argue with people in here? They don't calm me down. I know it don't calm none of these girls down."

"So let me ask you a question," Ms. Lewis said. "So why are you taking it?"

"Because I have to. If I don't take it I'm not never leaving here. I'm not going nowhere. I have to take it. I have Bipolar, alright?"

Ms. Lewis asked Makayla why she hadn't spoken to the doctor about taking a medication that actually worked for her. "I took everything in the book," Makayla answered. "I didn't take Trazodone or none of that that other stuff but I took Depakote, Seroquel, Abilify, Concerta, Risperdal. I took all of that… and none of that worked… Risperdal don't work."[2]

"That's too much medication," Ms. Lewis reflected. "That's too much medication. C'mon, you kids 13, 14, 15, 16, 17, 18 and all this medication in you. Oh my god."

"And imagine you been taking it since you mad young," Makayla said. "That mean your body accustomed to it. Like when they took me off of lithium I was just like. I was taking lithium and Seroquel at the same time. When they took me off of it I was like sleepy all the time, I had migraines, all that. They didn't ease me off of it. They just, [claps hands], took me off it. As soon as I got here. They took me off of it… I was taking it here. It made me good. It made me

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2. Trazodone is an antidepressant that belongs to a class of antidepressants known as SARIs (serotonin antagonist and reuptake inhibitors). Concerta (generic: methylphenidate) is a central nervous system stimulant used to treat Attention Deficit Hyperactivity Disorder. Seroquel (generic: quetiapine), Abilify (generic: aripiprazole) and Risperdal (generic: risperidone) are all atypical antipsychotics, also known as second-generation antipsychotics, because they are significantly different in structure and pharmacology from older antipsychotics such as thorazine and haldol.

calmer… cause I was a crackhead. When they took me off of it, they didn't ease me off of it, like lower dosage, they just took me off it."

"But you didn't complain about it?" Ms. Lewis asked.

"I complained about not being on it," Makayla answered. "Because you're not supposed to take a child off a medication that's so strong like that."

Ms. Lewis concluded, "they supposed to ease you off. They should of just eased you off a little bit."

YOUTH PERCEPTIONS OF MENTAL HEALTH

There is much to tease out in the conversation just presented. I start by considering how the turn to psychiatry within the space of GGI is remarkable because of how marginalized mental health problems usually are among this group. As described in chapter 4, the labels used in GGI often mirror symptoms on a *DSM* checklist for behavior disorders; residents employ a type of symptom-talk to describe their own behavior as well as the behavior of their peers. GGI labels like "easily angered," "not following directions," and "being disrespectful," for example, map easily onto the psychiatric symptoms of Oppositional Defiant Disorder such as "often loses temper," "often actively defies or refuses to comply with adults' requests or rules" and "is often spiteful and vindictive" (APA 2000). For the most part, however, GGI labels remain unconnected to mental health diagnoses in residents' discourse. When Brianna is first called to task for lying, no one in the group says that her behavior is symptomatic of Conduct Disorder. Nor do residents regularly resort to psychiatric diagnosis when they label themselves or account for their behavior. Instead, normalized descriptions of one's self and one's problems are offered, with patterns of negative behavior likely to warrant the labels of "no change, no growth" or "falling off track."

The fact that pathological descriptions of behavior are relatively rare and that problems are given a wide range of meanings is further brought out in data from eight in-depth interviews with juvenile justice residents. During the interviews I conducted, I asked participants to describe the problems they were having prior to coming to Edgewood or at the time of the interview, wanting to see if they would use any diagnostic language on their own. Two participants denied having any problems altogether, responding with answers such as "I ain't have problems," or "It wasn't about the problems. I was just bad." An additional three participants talked about problems but expressed them in relational terms. Sofia, for example, told me, "The issues I was having was 'cause my Mom. I don't know. I couldn't talk to her. And the way I express my feelings, I couldn't talk to her. My brother, I couldn't talk to him neither. So I couldn't talk to nobody. So how I would take it out was smoking weed and then fighting people and stealing their stuff" (Interview, September 8, 2010). Tiffany likewise mentioned her mother in describing the problems that led to placement at Edgewood: "Before, I just, I did what I wanted to do, how I wanted to do it, when I wanted to do it, and, if you had a problem with it, oh well… It's like I wanted to do my own thing. I wanted to get out. I felt like my Mom had me caged up, like this animal, and I just wanted to go… I felt like every time we argued, that was the best reason to leave" (Interview, August 18, 2010). The remaining three participants offered what might be considered more medicalized responses when describing their problems: one mentioned symptoms ("I'm hyper, easily angered, can't sit down") but no diagnosis, and two others referenced diagnostic categories (Bipolar Disorder and Depression).

When I asked more specific questions about whether residents had ever received a psychiatric diagnosis or whether they thought they had any mental health problems, participants again distanced themselves from psychiatry. Three of the eight residents told me that they had

never received any diagnosis, despite having had several mental health evaluations (all youth referred to Family Court in New York City undergo a mental health evaluation prior to receiving a disposition), as well as multiple diagnoses listed in their case records including Conduct Disorder, Cannabis Abuse, Adjustment Disorder, and Posttraumatic Stress Disorder. Other residents acknowledged having been diagnosed but disputed the results. Carmen, for example, was distressed that a court appointed psychologist had told her she was Bipolar. "I think I have depression. And maybe anger management," she told me. "But Bipolar? I don't think so!" Interestingly, Bipolar Disorder appears nowhere in Carmen's case records. Carmen told me during her interview that her clinician at Edgewood had informed her that there was no record of her having been diagnosed as Bipolar but she maintained that a court psychologist had given her the diagnosis at one point. "I don't know what else he said in the paper but he didn't write that on the paper but the first time he did," she told me (Interview, September 22, 2010). Overall, seven of the eight interview participants told me that they did not have mental health problems. Thus, even among participants who discussed being given a psychiatric diagnosis, the link between diagnosis and mental health was not automatic.

The tenor of the responses I received about mental health and diagnosis resonates with recent literature about the experiences of youth under psychiatric care (Carpenter-Song 2009a, 2009b; Floersch 2003; Floersch et al. 2009). This body of work suggests that even as psychiatry moves toward a biomedical model (Luhrmann 2000) and broad shifts toward medicalizing children's behavior take place, a range of meanings—many nonpathological—are still attributed to such behaviors at the local level of youth and their families. Carpenter-Song's (2009a, 2009b) study of 20 families with children diagnosed with behavioral and emotional disorders is particularly relevant to my work. Carpenter-Song found that especially among African American

families in her study (63 percent of the population at Edgewood), there was strong resistance to

pathologizing behavior; the account of one family was "suffused with a rhetoric of self-control

and personal responsibility" (2009a:80). As described in the introduction, personal responsibility

is also an organizing framework at Edgewood—not only in the area of mental health, but also in

terms of one's entire experience at Edgewood. Carpenter-Song concludes that "for most children

in the larger study, mental health concerns remain muted in their lives" (2009b:263). The

interviews I conducted resulted in similar impressions about how mental health concerns are

integrated into the lives of many Edgewood youth. In the face of so many competing struggles—

poverty, school failure, substance abuse, parental abandonment—it makes sense that mental

health may not be a primary concern among this group.

Given that mental health often seemed marginal in the lives of the youth I interviewed, it

is worth noting that the interviews also revealed a substantial level of confusion about the

category of mental health. To begin, when I asked questions about mental health treatment and

diagnosis during interviews, participants were not always sure what I was asking about, often

equating these terms with medication. For example:

L.P.G.:   I want to talk to you a little bit about your experiences getting mental health treatment.

Resident: Taking meds?

Another example from a different resident:

L.P.G.:   Have you ever had any mental health diagnosis?

Resident: That's meds, right?

The purpose of the mental health evaluation that juvenile justice residents undergo prior to

receiving a disposition (i.e., sentence) was also unclear. Having looked at clinical reports in

residents' case records, I know that these evaluations ask residents to talk about their family

history, the conditions surrounding their arrest, and previous psychiatric care they may have received, among other topics. Almost always, however, residents recalled the cognitive testing portion of the evaluation first and did so with negative emotion. "They be asking me retarded questions like I'm dumb or something," Clarice remembered. "They was asking me, like, how to spell stuff, how to spell backwards, count, count one through five" (Interview, July 24, 2010). Sofia had a similar memory: "Dumb questions… like shapes and stuff like that… like, 'you know I know the answer to this, why you asking me this?'" (Interview, September 8, 2010).

Collectively, residents' reflections about their mental health and diagnostic history, as well as about their mental health evaluations, create a sense that these youth are neither focused on the category of mental health nor well informed about the diagnoses they have been given and the content of their case records. But this is exactly what makes the turn to psychiatry within GGI all the more interesting. For a group of girls who largely express their firm sense of well-being, the ensuing discussion on psychotropic medications and Bipolar Disorder is striking. In the rest of this chapter, I show how slippages occur between normalized and medicalized understandings of experience by looking specifically at the information exchanged about psychotropic medication and Bipolar Disorder; what appears at first to be a disruption in the normal routine of GGI becomes a moment where alternative versions of one's self are tested.

TAKING PSYCHOTROPIC MEDICATIONS

While the beginning of this vignette shows a group of girls berating Brianna for lying about a relationship with another resident in Hamilton Cottage, the conversation is shifted dramatically at the moment when Ms. Lewis declares her belief that Brianna's medication is not working. The resulting discussion demonstrates that residents have considerable knowledge about psychotropic medication and that they take seriously the meaning that is attached to taking

them on both a physical and philosophical level. To begin, it is clear that residents are intimately familiar with the world of psychotropic medication, even if they lack technical knowledge about such drugs. Amber, for example, appears to know the amount of medicine Brianna takes each day and is able to reason that the side effects of medication are based on the dosage in relation to one's body size (i.e., weight). Makayla, meanwhile, rattles off a list of psychotropic medications with ease, testifying to a long history of being medicated. She ends the conversation by describing her knowledge about weaning people off medication slowly rather than all at once—a common clinical practice.

The knowledge about these medications may not be surprising given the rapid increase over the last two decades in the number of youth who have been prescribed psychotropic medications. Between 1994–95 and 2000–01, the proportion of physician office-based visits resulting in psychotropic prescriptions for 14–18 year olds rose from 3.4 percent to 8.3 percent (Thomas et al. 2006:65).[3] Nearly five percent of U.S. children ages 4–17 were prescribed medication for behavioral and emotional difficulties between 2005 and 2006 (Simpson et al. 2008:1). The proportion of youth in the child welfare system who have been prescribed psychotropic medication is even higher. Studies of youth in child welfare show rates of medication use ranging from 13 percent to 37 percent (Leslie et al. 2010:135) and studies of youth in residential placements (therapeutic foster homes, group homes, residential treatment facilities) show even higher rates, with between 49 percent and 79 percent taking psychotropic medications (Breland-Noble et al. 2004:707, Connor and McLaughlin 2005:307, Handwerk et al.

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3. The total number of visits resulting in psychotropic prescriptions for this age group increased nearly twofold (191.7 percent) over seven years. In comparison, the number of visits that resulted in a prescription for a non-psychotropic medication increased by only 6.2 percent (Thomas et al. 2006:65).

2008:523).[4] Edgewood fits in between these estimates. As of the fall of 2011, 39 percent of

Edgewood residents were taking medication; the figure was relatively higher for female residents

(45 percent) than male residents (35 percent). Although Edgewood staff try to minimize the use

of medication (as described in chapter 3), it is clear from these numbers that many female youth

on the campus are familiar with being medicated and have cobbled together a body of knowledge

about these medications as a result.

"It Really Change People"

Beyond any technical knowledge acquired about psychotropic medications, of course,

there exists the lived experience of taking such medications. Floersch (2003) and Floersch et al.

(2009) argue that little research has examined how adolescents subjectively experience

medication—a gap that is especially glaring since adolescence is a primary period of identity

formation. Floersch asks, "what does it mean for an emerging 'self' to be medicated?" (2003:57).

As the dialogue in the vignette makes clear, several residents and Ms. Lewis subscribe to the

belief that taking medication has real effects—physical, behavioral, and emotional.

Some of the changes described are physical or bodily ones. Ms. Lewis states that

Brianna's medication is not working because she is awake all night (the assumption being that

the medication should have a sedative effect). Makayla claims lithium "made me calmer" and

also recalls that going off lithium made her "sleepy" and gave her migraines. Her description of

the effects may be inconsistent, (especially in light of what else she says in this discussion, which

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4. It is worth noting a methodological problem with several of these studies: many do not identify whether study participants are living in out-of-home placements or define the type of placements being studied (e.g., what counts as residential treatment).

is discussed below), but Makayla still highlights unwanted side effects to her medication.[5] At least from one angle, then, Makayla makes sense of her medication by its effects on her body.

The belief that medication should sedate and calm residents is linked in turn to the effects of medication on behavior. It is clear to me that residents understood that, for the most part, they were being medicated for "trouble-making" behavior. Keshanna suggests "medication should be stopped" but then she reconsiders, saying, "There would be hell" in the cottage if residents were taken off their medications. Ms. Lewis adds, "There won't be no staff." It was clear from the tone of this exchange that a certain amount of jest was involved. But the sentiments expressed also reveal residents have been told—or have come to believe—their behavior is something in need of regulation and medication is something that can help them achieve this goal. Indeed, even the adult in this example attributes the power to change not to the individual but to a pill.

In addition to the physical and behavioral changes that are ascribed to psychotropic medications, the dialogue reflects a sense that more substantive changes can result from taking medication—ones that disrupt an individual's sense of self. Keshanna says this most directly when she declares, "I think medication should be stopped because it really change people." Keshanna does not describe the changes she is referring to but she speaks from a privileged vantage point: not only is she on psychotropic medication herself, but she also has been at Edgewood for over five years. Keshanna thus draws on years of observation when she makes this comment. Keshanna articulates a certain fear that she and her peers are no longer their true selves when they take medication. Her perspective speaks to the fact that there are myriad ways

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5. Side effects clearly vary by type of medication. The chief complaints that I heard from residents—regardless of the medication they were taking—included drowsiness, dry mouth, and weight gain. The issue of weight gain for female adolescents taking psychotropic medications deserves further exploration, given that self-image at this age is so central. McCloughen and Foster's (2011) review of literature on the impact of psychotropic-induced weight gain describes several studies that have linked negative self-image and low medication adherence to weight gain in adult populations but note the relative lack of literature on adolescents (Pogge et al. 2005 is an exception). Although compliance is not the focus of this study, it is worth highlighting that some youth are quite distressed by the side effects they experience and may request a medication change or stop taking medications altogether as a result.

youth make sense of taking medication and that the experienced effects of these medications may not always be what youth desire.

"None of That Worked"

Even as residents claim that psychotropic medications produce changes—to the body as well as to personhood—Makayla's position in the vignette suggests an alternate reality: that medications fall short of achieving their expected effects and are not sufficient treatment on their own. In regards to falling short of expected effects, Floersch et al. (2009:173) argue that a gap exists between the expected ("hoped-for or desired") and the experienced effects of medication. This gap is narrow when medicine is believed to be the agent that delivers change, as in the case when a cured headache is credited to aspirin. But the gap may be particularly large in the case of psychotropic medications since the anticipated effects are not always well defined. As Floersch et al. write, "In relation to reducing or eliminating psychiatric symptoms like depression, anxiety and irritability, the expected effects may be elusive, transient, or difficult to pinpoint" (2009:173). Returning to Makayla, we find her stating that her medications do not have the anticipated effect of calming her down. "You could take a pill – wow! It's shooting in your body making you tired that's it. It's not calming you down. You know how many times I took my meds and still do things, or still argue with people in here? They don't calm me down. I know it don't calm none of these girls down."

Makayla also believes that medications alone are unhelpful. She reasons, "You could take medication and still not be getting the help, like you don't have nobody to talk to, you still gonna be depressed, you still gonna be angry, you still gonna be sad." While Makayla's statement

echoes literature suggesting medication and psychotherapy are most effective in conjunction,[6] I

think Makayla is speaking from personal experience here. She highlights how medications may

have no meaningful effects on emotions—one remains "depressed," "angry," and "sad,"—even

if they appear to impact the body and behavior; there is a disconnect between the effects of

medication observed by outsiders and those experienced by individual youth.

Justifying Medication Usage

After Makayla disputes the efficacy of medication, it is understandable that Ms. Lewis

would ask her why she continues to take the medications. For Makayla, however, there is no

contradiction between her belief that her medications don't work and her continued adherence to

them. She develops two separate explanatory schemes to rationalize the fact that she "has to"

take her medication. In the first scheme, Makalya ties medication adherence to her discharge

from the Edgewood campus. "If I don't take it I'm not never leaving here. I'm not going

nowhere," she states. It is unclear whether Makayla was told that she must take medication as a

condition of her discharge. On the one hand, it seems unlikely that this would be stated directly

since the campus tries to use medication sparingly. The psychiatric Nurse Practitioner whom I

interviewed was also realistic about the challenges of medication adherence among youth:

> By the time someone has reached adolescence, they want to make their own decisions.
> We try to work with them with that, and so I think what we try to do, if a child is saying
> "I don't want medication, if I don't need medication, I want to be off medication," what
> we will try to do is take them off, but then work with them to see, okay, to make an
> agreement with them, if you continue to have problem, or your problems get worse, or
> you really are getting in trouble, we'll work with you. You may need to go back on it. We
> try to work with them in that way. To force an adolescent to take medication is really,
> there's no point to it. As soon as they leave here, they're going to stop because they don't

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6. Research on the differential effects of psychotherapy and medication is growing but difficult to cover
comprehensively because of the various types of psychotherapy (cognitive, behavioral, psychodynamic,
interpersonal, etc.), the multiple medications available, and the different disorders being treated. Nonetheless, there
is evidence that using psychotherapy and pharmacotherapy may provide better outcomes that either modality alone
(Gabbard 2006).

> have a recognition, if they do need it, that maybe they need to stay on it. [Interview, November 10, 2010]

On the other hand, given that the attitude of "do what you gotta do" prevails at Edgewood, it is certainly possible that a staff member mentioned compliance with medication as falling into this category, or that Makayla interpreted the "do what you gotta do" attitude broadly to include medication compliance. In either case, Makayla clearly feels that she must take her medication to prove that she is ready to be discharged from the campus. This is an explanation that holds weight on a campus where most youth are counting down the days until they can go home.

Makayla offers a second explanatory scheme to rationalize her need for medication, however. Repeating that she "has to" take the medication, Makayla states, "I have Bipolar, alright?" From Makayla's perspective, the claim to having Bipolar Disorder legitimizes her use of psychotropic medication; she references an illness identity as a way to make her medication treatment meaningful. Makayla's rationale also appears to have the same legitimizing effect on the larger group. If at first Ms. Lewis asks why Makayla is taking medication at all, once Makayla says, "I have Bipolar," Ms. Lewis changes course and reframes the question to ask why Makayla hasn't spoken to her doctor about finding a more appropriate medication. Claiming to have Bipolar Disorder therefore serves a function. In the remainder of this chapter, I consider more fully how referencing an illness identity works in this setting by turning attention to Brianna. Brianna claims she is Bipolar early in the vignette but then fades into the background of the conversation. While Brianna may seem like a secondary character, what happens in response to her declaration is in fact more suggestive of how the identity of Bipolar Disorder works in this environment. I argue that invoking a psychiatric label creates an important orientation shift among the larger group of peers and works at once to forgive and discredit.

If we return to the beginning of the vignette presented above, we witness Brianna being called to task for lying about her relationship with another female resident in the cottage. The relationship itself is not the central focus. It was common knowledge at this point that Brianna and Tanya were "going out," and my perception from months on the campus is that same-sex relationships are common. Rather, residents and staff in Hamilton were tired of Brianna's lies. Brianna had been transferred to Hamilton Cottage from another cottage two months earlier. In my field notes from the intervening time, Brianna's lying had been the focus of multiple GGI meetings. While Brianna vocalized in previous meetings that, "lying makes no sense," she continued to lie regularly. "You're a constant liar. You lie about simple things," Ms. Austin told her at one point.[7] By this time, then, the standard GGI advice—"you're falling off track… get back on track"—is no longer sufficient as an explanation of and remedy for Brianna's behavior. Brianna constitutes someone who is "falling deeper." Or, as one staff member said to another resident but might just as easily have said to Brianna in this case, "The track is not even near you. The track moved."

When the standard GGI advice fails, new spaces open up in which to insert alternative explanations of behavior—spaces that, in this case, are filled by turning to psychiatry. It is Ms. Lewis who first directs the conversation toward psychiatry when she declares that Brianna's medication is not working and then asks Brianna if the medication is helping her. But Brianna's response to the question about medication is not simply to answer, "No." She adds a qualifier: "I'm Bipolar." What are we to make of the fact that Brianna announces to her peers and her staff

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7. Some of Brianna's lies might be considered trivial—she lied about having a cell phone on campus, for example, which is not allowed but relatively common—but others were more serious. Brianna told several peers and me that she was pregnant on multiple occasions despite the fact that a nurse had taken a pregnancy test and the test had come back negative.

that she is Bipolar? It is hardly irrelevant that I learned separately that Brianna has not been

diagnosed with Bipolar Disorder. What I want to focus on, however, is the status that the label

"Bipolar" takes on here and the work that this illness identity performs.

It is not clear from this particular exchange that the lay knowledge these residents possess

about Bipolar Disorder has anything to do with the clinical picture; they do not discuss the

features of the disorder at all. I have limited data on how female youth at Edgewood define

Bipolar Disorder or what they think are the salient features of the diagnosis. The data I have

suggest that Bipolar Disorder is equated with mood swings, however mild. Clarice articulated

what Bipolar Disorder meant to her in our interview:

> People kept on saying that I was Bipolar but I didn't believe it. But now I feel like, 'cause Ms. Austin keep on saying I need to control my mood swings... at first when she started saying that I didn't believe, I still didn't believe I have Bipolar. But like when she catch me in my actions that's when, that's when she'll say something. And I was like, "oh I do have Bipolar." Like let's say, I had an argument with somebody. And Ms. Austin was like, "you mad now." Like later on… like five minutes later, I'm playing with somebody [and] she'll be like, "see this is what I'm talking about." [Interview, July 24, 2010]

Residents do not articulate the features of Bipolar Disorder in this vignette but it is clear that

these residents are familiar with the diagnosis and that it holds some power. The status of and

residents' familiarity with Bipolar Disorder may not be surprising in light of recent diagnostic

trends. Since the mid–1990s Bipolar Disorder in children and adolescents has gone from being

almost unknown to being one of the most common primary diagnoses in this population.

Whereas community-based epidemiological studies have found the lifetime prevalence of

Bipolar Disorder in adolescents to be between 1.0 and 1.4 percent, its occurrence in more

specialized psychiatric settings ranges from 10 to 30 percent of patients (Kowatch 2009:2).

Perhaps more informative is the fact that between 1996 and 2004 the number of adolescents

discharged from the hospital with a primary diagnosis of Bipolar Disorder increased fourfold

(Blader and Carlson 2007:109). This dramatic rise has been contributed to several factors, the most convincing of which—from an anthropological perspective—is the suggestion that the increase in diagnoses may reflect a progressive "re-branding" of the same phenomena for which adolescents formerly received different diagnoses like Conduct Disorder. As Blader and Carlson suggest, "the unchanged rate of conduct problem diagnoses over the survey years [1996–2004] represents an effective decline in light of the marked rise in overall population-adjusted rate of children's psychiatric discharges" (2007:112). Given that diagnosis has become a currency of value in the context of managed care (Hopper 2001; Lester 2009), it is also likely that clinicians have responded to higher hurdles for obtaining payment by "upcoding" behavioral disturbances to a major mood disorder (Blader and Carlson 2007:112).

Whatever the reasons behind the broader shift in diagnostic practices, it is clear that in Briana's case, Bipolar Disorder holds strategic value. Stating, "I'm Bipolar," provides Brianna with both a defense of her behavior as well as a means to subvert the regular structure of GGI. Estroff et al. (1991) have described "I am" and "I have" declarations as "illness-identity statements" that serve to account for one's condition. In contrast to "normalizing statements," which dispute the assignation of illness and recategorize conditions as common or nonpathological, "illness-identity statements" such as "I am" provide a substitute identity that locates the individual in relation to illness or diagnosis (Estroff et al. 1991:337). For some, "the mantle of medicalization" may be embraced because of the "'no fault' provisions of having an illness" (Estroff et al. 1991:362; see also Parsons 1951 for an earlier discussion of the "sick role"). In Brianna's case, claiming to have Bipolar Disorder offers a justification for why her medication is not working, why she is "up all night" as Ms. Lewis claims, and even, perhaps, why she lies; she is to be forgiven for these "transgressions" because she is Bipolar. Moreover,

once she reveals she is Bipolar, Brianna does not speak—nor is she spoken to—for the remainder

of the meeting (it is especially interesting that Brianna is spoken about in the third person even

though she is sitting in front of the group). Whereas the traditional GGI format would have made

Brianna take responsibility for her behavior and then listen to her peers' suggestions for redress,

here she diverts focus off of herself entirely and avoids having to provide any explanation at all;

the Bipolar diagnosis is enough.

Yet, the Bipolar diagnosis also holds a certain value for the rest of the group in this

particular GGI meeting. Just as Brianna's Bipolar diagnosis exempts her from having

responsibility for her behavior, so too does it free the group from being responsible for her. GGI

is built on the premise that youth will assume responsibility for helping one another. Brianna's

peers are frustrated with her, though; she has been the focus of many past meetings. In some

ways, then, Brianna's claim to being Bipolar also lets them off the hook, providing a psychiatric

justification for behavior that is otherwise inexplicable. This process is similar to the one that

Rebecca Lester (2009) describes in her examination of "borderline talk" at an eating disorder

clinic. Lester illuminates how borderline personality disorder claims "explanatory purchase" in

accounting for clients' difficulties in treatment. In a place where managed care organizations

dictate treatment—often forcing clients to be discharged before clinicians believe it is wise to do

so—"borderline talk" emerges as a way for clinicians to reframe clients as lacking authenticity

and, therefore, unfit for continued treatment (the rationale being that "you can't treat

borderlines" (Lester 2009:291)). This reframing allows clinicians to make treatment decisions

they consider ethical even when such decisions contradict their clinical judgment (Lester

2009:285). Brianna's case is different, but I think the articulation of Bipolar Disorder operates

for her in much the same way that "borderline talk" does for Lester's client. When the peer group

accepts Brianna's claim to this diagnosis, they simultaneously pronounce her unfit to be the proper subject of GGI. And, because her behavior is the result of psychiatric disorder, it is beyond the purview of peer advice. In this sense, claiming to have Bipolar Disorder discredits Brianna as an individual just as much as it provides her with space for forgiveness.

Living Under a Diagnosis

If Brianna recedes into the background of the conversation once she is deemed Bipolar, questions about how her acceptance of this diagnosis converge with her own sense of self do not. It is unclear from the vignette how Brianna feels about being seen as Bipolar. Consider, however, the broader issues at stake here, namely, the ways in which the category of Bipolar Disorder creates a new space for Brianna to inhabit and a new self for Brianna to embody.

To begin, being labeled as Bipolar links Brianna to a particularly negative set of associations related to gender and race. Emily Martin (2007) has suggested that American culture has a strong affinity with manic behavior, much of it accentuating the productive and creative value associated with Bipolar Disorder. But the manic energy Martin argues is extolled in the United States is male and white; she largely ignores what happens when extreme emotions are expressed by a woman or a person of color. Given that Brianna is female and African American, the assignation of Bipolar Disorder is likely to carry very different connotations for her than for a white male. In particular, the historical record demonstrates that as it relates to gender and race, mania has been associated with unbridled femininity (Lunbeck 1994) and "primitive" racial otherness (Corrigan 2002). Martin mentions this but only briefly and, notably, separately; she accounts for gender and race individually but fails to account for the ways that they combine in potentially more pernicious ways in the context of this particular diagnosis.

Viewed from this perspective, Ian Hacking's work on "making up people" (1995, 2002, 2004, 2007) remains especially relevant. But I return to Hacking here with specific reference to his idea of the "looping effect." For, if Bipolar Disorder has the ability to reshape Briana, so too does Briana contribute to shaping what is known about Bipolar Disorder; a "looping effect" is put into motion that shifts the ground of meaning beneath the diagnosis (Hacking 2004). Thus, just as Brianna may change her behavior as a consequence of referencing the Bipolar diagnosis, those around Brianna may alter their conception of what Bipolar Disorder encompasses. The process is particularly interesting in this case because Brianna has never received an official Bipolar diagnosis. Brianna may really believe she has been diagnosed as such or she may simply be enacting what she believes are the characteristics of someone who is Bipolar. In either case, she reshapes the boundaries of the Bipolar diagnosis for herself and for her peer group.

With Hacking in mind, it is worth considering how living under the diagnosis of Bipolar Disorder—however "true" the diagnosis—changes the space of possibilities for Brianna's personhood; who she is and who she can become are now inscribed and, I argue, circumscribed, by bipolarity. Indeed, Brianna's claim to Bipolar Disorder may be strategic at first—giving her room for forgiveness—but so too does it discredit her among her peer group. That Brianna's struggles on the campus escalated after this GGI may not be surprising. Within one week of the meeting, Brianna told me that she wanted to be hospitalized, claiming, "I need a break from this place." Three weeks later, she repeated this desire again, adding, "I'm so depressed, it's not even funny." Brianna got her wish soon after when she was admitted to an adolescent inpatient unit for a two-week stay. While it is complicated to account for the decision to hospitalize Brianna (I was not part of the discussion that led to the decision), it is clear to me she interpreted her hospitalization as a mandate to change. She wrote me a letter from the hospital that indicates this

much: "While I wuz N the hospital it made me think about a lot of things n life… being N the hospital makes you think wat yew are going 2 bee doiing when you go bacc. That's exactly what I thought about. It's a new Brianna. dead serious. You will c."

Brianna saw herself as someone in need of a new and improved self. This sentiment was also reinforced from above, however. Upon Brianna's return from the hospital, a staff member asked her if she had received "help" at the hospital. "Did you get the help that you went for?" the staff member asked. When Brianna responded affirmatively, the staff member continued, "so you're not supposed to come back the same way." The comment was serious but the irony of it was not lost on me. This staff member expected the hospital to accomplish what Edgewood was responsible for in the first place: changing youth. Brianna did not have much of a chance to prove herself a changed individual though. Within six weeks of her return, she went AWOL from the campus for a month.

CONCLUSION

In this chapter I investigated how new selves emerge within GGI. GGI aims to reshape youth into individuals who conform to conventional social rules; youth are taught to recognize and articulate problems with their behavior and attitudes through peer confrontation. But in the space between the textbook GGI and everyday version practiced at Edgewood, new possibilities arise. Whereas in chapter 4 I argued that a more introspective—but never forgiven or healed—self is brought into being through GGI, in this chapter I showed that youth also actively assert alternative versions of themselves. Some of these selves are medicated and others are defined by diagnostic categories. In either case, they are intentional and strategic, embodied by youth who wish to convey something particular.

I have also suggested in this chapter that medicated and Bipolar selves are products of recent historical trends. Youth at Edgewood find themselves in residential treatment at a unique time—a time in which the broader "sociocultural milieu organiz[es] experiences around *DSM-IV* categories and medication treatment" (Floersch et al. 2009:172). The dramatic rise in psychotropic medication prescriptions and the almost unbelievable increase in the number of youth who are diagnosed as Bipolar suggest that youth today can experiment with psychiatric identities in ways that simply were not possible before the 1990s. Thus, although residents at Edgewood may generally deny having mental health problems or having ever been diagnosed with psychiatric disorders, they simultaneously realize the power and value that diagnoses hold.

Insofar as this study has been concerned overall with the multiple ways that female youth are constructed within a residential treatment environment, this chapter also argued that there are real—though perhaps less well understood—consequences to being classified in particular ways. The Bipolar diagnosis becomes an easy way for Brianna to avoid taking responsibility for lying and it also signals to her peer group that they need not be responsible for her. Yet, even if Brianna is forgotten in conversation once she declares she is Bipolar, questions linger about her own sense of herself. Snapshots of Brianna's behavior after the GGI meeting show a girl who comes to believe that she needs a period of hospitalization in order to escape her reality at Edgewood. We can only wonder whether she wanted to escape the Bipolar identity as well.

CONCLUSION: FROM ONE 'HOOD TO THE NEXT

As a means of concluding this study, I turn to the themes of exit and transition. Inevitably, all residents at Edgewood will be discharged. Juvenile justice youth will serve out their dispositions or be sent home early through new initiatives providing alternatives to placement, foster care youth will return to their biological families, find new foster homes, or eventually age out of the system, and special education residents will transition back to their home schools or graduate from high school at Edgewood. The process of transitioning from the institutional world of Edgewood back to the community is anything but straightforward, however, and many of the contradictions discussed in these chapters play out during the discharge process. In these final pages, I describe the situation of one resident who was discharged shortly before I concluded my fieldwork. My goal in illuminating the case of one particular individual is to reflect on some of the broader themes I have pursued in this work and to resituate this study within the broader context of residential treatment and juvenile justice in the United States. In so doing, I hope to call attention to some of the policy implications that arise from this study.

"GOING HOME TO THE SAME PLACE"

I interviewed 15-year-old Chantel on the day before she was discharged from Edgewood in September 2010. Arrested for shoplifting in the summer of 2009, Chantel had spent over 100 days in non-secure detention while her trial was pending and was subsequently ordered to spend 12 months at Edgewood (minus two months for "time served"). Now on the eve of her discharge, Chantel reflected on the contradictory nature of her placement. On the one hand, Chantel articulated her sense that being at Edgewood helped her "grow." She believed the experience of

living away from home had given her the tools to live on her own in the future, and she was especially thankful that being at Edgewood had given her the opportunity to re-engage in school, something she admitted she would not have done otherwise. As she told me, "I came to Edgewood, they helped me and then I made it, I made it. It helped me. And, I ain't gonna lie. Even though she [judge] sent me here, I didn't want to be sent here, it did help me. I made it help me" (Interview, September 23, 2010). Chantel credited Edgewood with helping her change while simultaneously recognizing her own agency in effecting those changes.

On the other hand, Chantel was acutely aware of the disconnect between the Edgewood environment and her home community in Brownsville, Brooklyn, and of the ensuing irony of her discharge. Chantel told me—and her court reports confirmed—that one of the primary reasons she was sent to Edgewood as opposed to being allowed to remain in the community was because of her unstable home environment. During the time Chantel was in non-secure detention awaiting her disposition, her mother had been arrested for a parole violation and sent to prison. Her father was also in prison. While Chantel hoped she would be able to go home to live with her grandmother, the judge in her case did not think her grandmother could provide a suitable home at the time; Chantel's grandmother just recently had been released from Bedford Hills Correctional Facility after serving three and one-half years for selling a controlled substance. She was now on parole. Now, one year later, Chantel would be returning home to live with that same grandmother. Chantel understood the judge's initial reasoning for placing Chantel at Edgewood but noted the paradox of her placement and discharge with a certain wistfulness:

> I always thought like, I don't know what she succeeded by sending me here… I don't understand the reason why, the reason she sent me here. And then I'm still gonna go home to the same environment that she thought wasn't good for me. I'm still going home at the end of the day to the same place… So what's the point of her sentencing me? I just don't understand that. [Interview, September 23, 2010]

Chantel captures remarkably well the irony of being discharged to a home that was previously deemed unfit. If Chantel's apartment in Brownsville had not been suitable for her in 2009, what made it acceptable in 2010? Chantel's grandmother was required to complete parenting classes prior to Chantel's discharge but Chantel would still be returning home to live in a community that she described as "a horror." Perhaps not surprisingly, Chantel expressed some reluctance to leave Edgewood even though she had been counting down the days until her discharge. "I just want to be with my grandmother, so I really want to go home," she told me in our interview. "But I don't know. I'm used to it here."

Although Chantel is only one resident of the many who are discharged from Edgewood each year, her case is not especially unique; there are many residents whose complicated family dynamics create challenges at the point of discharge and there are even more who are returning to neighborhoods with entrenched poverty and its concomitants of unemployment, homelessness, substance abuse, and parental incarceration among other phenomena. As such, Chantel's case provides an opportunity to reflect on some of the key themes I have pursued in this study: the way that youth are often enmeshed in multiple governmental systems at once, the lasting ambivalence about how and where youth are best served, the uncomfortable tension between the "inside" world of Edgewood and the "outside," and the locus of responsibility for personal transformation. I discuss each of these themes in turn before broadening my focus to reflect on the notion of making and remaking female youth that has framed this study.

Intersecting Systems of Governance and Care

One of the primary arguments I have made in these pages is that there is significant overlap between the juvenile justice (OCFS) and foster care populations (ACS). Though this study was initially conceived as a study of juvenile justice residents, it became clear throughout

my fieldwork that there was little to distinguish these residents in terms of background and that

to write about them independently would risk adding further confusion to the landscape of

residential treatment. This is not to say that OCFS and ACS categories are irrelevant. To the

contrary, I have argued they take on important meanings within the world of Edgewood as staff

and residents alike come to associate specific characteristics with each category and to make

corollary assumptions about the level of clinical intervention required. This surely impacts how

residents understand their position at Edgewood and the way they interact with both their peers

and adults on the campus. Even so, as Chantel's case demonstrates, many Edgewood residents

do not fit neatly into OCFS or ACS categories. In fact, of the ten OCFS case records I reviewed,

nine residents had a history of ACS involvement. Such data attest to the fact that OCFS residents

are not just youth who have committed crimes. Like their peers who are referred by ACS, they

have complex histories punctuated by episodes of abuse, neglect, and abandonment, as well as

parental substance abuse and incarceration.

The incorporation of the New York City Department of Juvenile Justice into ACS is a

welcome reform given the extensive evidence of overlap between juvenile justice and foster care

youth. Even so, it is questionable whether the merging of these two systems will have any

material impact on the way youth are perceived and categorized by adults. The clinical data I

presented on Edgewood residents' psychiatric diagnoses, for example, suggest that there is

significant bias in the diagnoses that OCFS youth are given compared to their ACS peers, with

juvenile justice youth significantly more likely to be diagnosed with a Disruptive Behavior

Disorder and foster care youth significantly more likely to be diagnosed with Bipolar Disorder.

As I have argued consistently throughout this study, following Ian Hacking, these diagnoses are

meaningful even if they tell us very little about the subjective experiences of the people living

beneath them; they shape youth in obvious ways and in ways that are perhaps less obvious. This is not to say that OCFS and ACS youth are diagnostic casualties, seen only as a facsimile of their diagnosis (a point I will return to later in this conclusion). But to the extent that youth from different referral sources receive unique psychiatric diagnoses—which are then re-entered in case records over time—it is worth considering the source of these biases and the extent to which they perpetuate longstanding misconceptions about these populations. The stakes are even higher when diagnoses that label disruptive behavior as pathological are being applied to adolescent girls who are minorities and from the lowest socioeconomic brackets of society.

Enduring Ambivalence About Residential Treatment

In addition to pointing to the ways that a single youth may be involved in multiple systems at once, Chantel's story reminds us that there exists lasting ambivalence in the United States about how to respond to youth who do not conform to societal expectations of appropriate behavior. Since the beginning of the 19th century, Americans have created institutions to remove members of society with the belief that a carefully designed environment has rehabilitative potential. The historical record and current evidence about mass incarceration demonstrates that in many cases these rehabilitative ideals have been undermined by harsh systems of punishment and coercion. In turn, there have been recent calls to move away from institutionalizing youth and to reinvest in community-based services. The Task Force on Transforming Juvenile Justice that was launched in September 2008 by former New York State Governor, David Patterson, is a key example of the resources being dedicated to finding alternatives-to-placement for youth who commit low-level crimes. The members of the Task Force highlight a deeply troubled system that demands change if the best interests of youth are to be a pillar of juvenile justice.

At the same time, the tendency to focus on the most extreme cases of juvenile confinement distorts understanding of the landscape of youth placements today. The New York Family Court Act calls for judges giving a disposition in a delinquency case to consider "the least restrictive available alternative… which is consistent with the needs and bests interests of the respondent and the need for protection of the community" (New York Family Court Act §352.2 (2)(a)). The Task Force proposes amending the act so that "the court may order institutional placement only when a child poses a significant risk to the public safety and, even then, only when no community-based alternative could adequately mitigate that risk" (2009:14). This may sound reasonable but by removing language about "the needs and best interests of the respondent," the Task Force suggests that "institutionalization" is never consistent with these concerns. Such a perspective contributes to the erroneous assumption that all youth placements in the juvenile justice system are highly restrictive environments with little to offer youth. It also rests on the belief that youth always can be served adequately in their own communities, a lofty ideal but one that surely deserves further research. My study of Edgewood attests to the range of placement options available and to the fact that youth can and do receive services in institutionalized settings. Given that most of the juvenile justice residents in Hamilton and Thayer Cottages had been ordered to community-based programs prior to placement without success, Edgewood remains an important option in the continuum of services for youth—even for those who do not pose significant risks to the community.

Indeed, it is worth recasting residential treatment as something other than a place of confinement or a substitute for families that have failed. As Whittaker and Maluccio note, various forms of placement should be seen "as potential options and basic supports for families that struggle with multiple problems and challenges, as opposed to being viewed as substitutes

for families that have failed" (2002:128). To view placement as a support as opposed to only a substitute might allow for Edgewood to be re-envisioned as a valuable and necessary place of escape in the world. Similar to how Wacquant describes a boxing gym in the middle of Chicago's South Side ghetto as an "island of order and stability," Edgewood can serve as a safe haven for many youth who have grown up in hostile environments (2004:26). To stay with Wacquant, it is only when one considers "the structure of life chances offered—or denied" on the outside that membership within Edgewood acquires its full social meaning (2004:18). It seems shortsighted to write off residential placement entirely when the life chances available outside of Edgewood have been so powerfully circumscribed.

The Tension Between 'Hoods

Of course, allowing for a more balanced view of residential treatment centers like Edgewood does not necessarily resolve the real tension between the inner world of Edgewood and the outside neighborhoods from which its residents come. Wacquant describes the boxing gym as defining itself in a *"double relation of symbiosis and opposition* to the neighborhood and to the grim realities of the ghetto" (2004:17). The same might be said of Edgewood. The campus exists as a dramatic alternative to the urban ghetto but it also always subsists in concert with it, a symbiosis sustained in large part because of the fact that all residents at Edgewood are ultimately discharged to the community.

I have argued that this uncomfortable tension between the "inside" and the "outside" is one of the primary reasons Edgewood residents describe the campus as "the 'hood part 2." Residents reconstitute "home" within the space of residential treatment but they do so with full knowledge that their Edgewood home is a temporary one. As Chantel told me, "I'm still going home at the end of the day." In some ways then, it may be somewhat adaptive for residents to

bring in the outside and thereby ease the transition between the two worlds they are asked to occupy at once. But so too does it inevitably introduce some of the very things—drugs and gangs, for example—from which Edgewood is supposed to provide relief.

Although this tension is to some extent impossible to resolve—after all, residential placements cannot be permanent homes in the long term—I have suggested that the tension is exacerbated by the growing bias against residential placement and the simultaneous move to shorten lengths of stay for youth. How can Edgewood residents look at the campus as *anything but* a place of temporary confinement when a whole set of outside forces is intent on pushing them out? And if placements really are to become shorter and shorter, then what can be expected to occur during them? What do policymakers hope to accomplish in six months, for example?

In this regard, it is particularly important to think about what might be lost in the move to shorter stays. Research linking lengths of stay in residential treatment to future outcomes is limited and equivocal at best (and suffers from some of the very same methodological problems that plague research on residential treatment in general, including a lack of clear definition of placement type and populations served. Yet, there is some evidence that longer lengths of stay are significantly associated with the likelihood of obtaining a high school education (Ringle et al 2010:977).[1] For policy-makers concerned about the cost of residential treatment, it would be valuable to consider how upfront investments in youth in the form of residential treatment might prevent future societal costs; high school drop outs, for example, create costs in the form of lost

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1. Literature reviews by Hair (2005) and Curtis et al. (2001) point to the longstanding problems of effectiveness research in residential treatment settings. Notably, most of this research does not focus on the length of stay in residential programs. Evidence linking shorter lengths of stay with positive outcomes must be tempered by the fact that shorter lengths of stay may be a proxy for less severe psychopathology (see Hussey and Guo 2002). On the juvenile justice front, research on length of stay is linked to recidivism and arguments are made in a different direction. There, policy makers and advocates cite research showing that longer lengths of stay do not decrease recidivism (e.g., Mendel 2011:15; Mitchell-Herzfeld et al. 2008:96) and thus argue that earlier discharges pose no threat to the community.

wages and productivity (Ringle et al. 2010:978) and make up a large proportion of the prison population (Harlow 2003:3). To the extent that residential treatment may provide a space for youth to receive an education and gain occupational skills for the future, the investments in time and money seem well worth it. At the very least, Chantel's description of re-engaging in school as a result of being at Edgewood should give pause when thinking about shortening lengths of stay for youth in residential treatment.[2]

The Project of Change

This leads us to the final theme elicited by Chantel's story: the project of change at the heart of residential treatment and where responsibility for that change is said to lie. Chantel was clear in her assessment of Edgewood, attributing personal growth largely to her own agency. "They helped me and then I made it. I made it… I made it help me," she told me. From a psychological standpoint, such language is suggestive of an internal locus of control, whereby an individual believes she is the cause of most things that happen to her. The belief that one has the ability to control what goes on in one's life has been linked to studies of resilience among youth (Luthar 1991, 2003; Garmezy 1988; Werner and Smith 1982), as well as to studies of adults who have overcome the negative predictions associated with childhood poverty to achieve high levels of occupational success (Harrington and Boardman 1997). Viewed from this perspective, one might argue that Chantel's ability to "make it" is largely a result of her own internal qualities rather than anything specific to Edgewood.

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2. To help residents maintain consistency in their educational careers, Edgewood has recently begun applying for permission from local school districts for residents to continue their schooling at Edgewood as day students post-discharge. Many residents in Thayer and Hamilton Cottages returned as day students during my fieldwork and were bused to and from their homes each day. This is particularly important for ensuring residents take the state examinations required for high school graduation. Residents who are discharged in the middle of the school year may be off-sequence and not allowed to sit for examinations (or miss them entirely).

This study also has suggested, however, that in living at Edgewood residents are oriented to a framework which dictates they are always responsible for their actions. This is captured in the "do what you gotta do" attitude that prevails on the campus, as well as in the philosophy of Guided Group Interaction. As I have argued, a "do what you gotta do" attitude underlines the extent to which residents alone are responsible for change. The mantra is then reinforced within Guided Group Interaction, as residents learn that it is only by continuously verbalizing their problems that they can be transformed. The label "no change, no growth" is particularly telling in the sense that it emphasizes the need to change while also reminding residents of their inability to do so.

It is entirely understandable that Edgewood works toward cultivating personal responsibility in its residents. The insistence on a young person's ability to change has deep ideological and philosophical roots. The juvenile justice system in the United States was founded on the belief that youth deserve a system separate from adults because of their malleability and potential for positive change. Meanwhile, as Hacking (2004) demonstrates, "the idea that you make who you are, and are responsible for who you are, is as deep a tradition in Western philosophy as could be" (2004:283). Hacking suggests that an existentialist vision of the human condition—one that relies on the freedom to choose—is an optimistic one, allowing us to decide who we are even within a framework of essential characteristics and constraints. This is a lofty aspiration that deserves commitment, not only because it can help stave off an undercurrent of pessimism that runs through the world of child welfare. As Hacking writes, "virtue and authenticity consist in being well aware that one is choosing who to be, and in being responsible for those self-conscious desires" (2004:281).

Without entirely abandoning the commitment to an autonomous human being, I think it is important to temper such an existentialist attitude with the knowledge that most residents at Edgewood have come from and are returning to environments with multiple stressors over which they have very limited control. This reality restricts the extent to which transformative changes are possible within the space of residential treatment. It also suggests that how young people fare once they leave Edgewood is dependent on a whole host of conditions that have less to do with their personal choices and more to do with external circumstances. Returning to the literature on resilience, Michael Ungar argues that "there is growing evidence that resilience is as much dependent on the structural conditions, relationships and access to social justice that children experience as it is any individual capacities… children both exercise personal agency and are also constrained by the structures around them" (2005:446). Ungar's view resonates with Harrington and Boardman's earlier reflection that an internal locus of control may be of limited value if an individual lacks any real power to change his or her circumstances (1997:164-165). Together, these perspectives suggest that Edgewood residents are capable of making choices to change their lives but that they do so under particularly severe constraints. While this perspective is certainly acknowledged at the highest levels of the Edgewood organization, it is perhaps less well-translated at the level of individual cottages and youth. Such a perspective also points to the inevitable challenges that will arise when youth leave the Edgewood campus and transition back to their home communities.

Indeed, the project of change in residential treatment might be better understood as the beginning of a longer process of transformation that needs sustained investment from multiple parties over time. Goffman (1961:22) imagined asylums as "forcing houses for changing persons" but his program was based on a long-term project of confinement and isolation that

simply is not possible in today's child welfare environment. Rather, the transitions that youth make back to communities—and the supports that they receive while doing so—are equally important areas for investment. Curiously, for a state that is so in favor of serving youth in communities, the provisions for aftercare across New York are disparate and underfunded. Youth in state-operated facilities receive aftercare services regardless of the time they are placed, and youth who take part in the Juvenile Justice Initiative are sent home early with intensive aftercare services. Yet, contract agencies like Edgewood are not required to provide aftercare services for youth who serve out the entire length of their disposition—nor are they reimbursed to do so (Citizen's Committee for Children 2000:4; Task Force 2009:70; Interview, October 27, 2010). Edgewood has taken the initiative to ensure that these residents are reconnected to school and have access to necessary services (e.g., mental health) before discharge but there is no further oversight once residents are home (Interviews, October 28, 2010 and November 2, 2010). For a population of youth that has documented mental health and substance abuse problems among other issues, establishing continuity of care is especially important. Without such supports, it seems unreasonable to judge the "successes" or "failures" of residential treatment or its ability to "change" youth.

A Tale of Making and Remaking

As a final note, it seems appropriate to reflect on the concepts of making and remaking that have framed this study. The idea of "making up people"—borrowed from Hacking (2002)—has been central to my thinking from the beginning because of the strong evidence that "female juvenile delinquents" and "conduct-disordered youth" are relatively new kinds of people in the popular imagination. Female youth have always been involved in crime, of course, but it is only recently that there has been such a sustained preoccupation with—and fear about—them (see, for

example, Garabino 2006). Likewise, there have always been youth who have misbehaved and broken rules, but only in the last 30 years has there been a dialogue linking their misbehavior to psychiatric disorder. In each of these cases, there is a sense that qualitatively new types of people have emerged that did not "exist" in the same way before.

It is not simply a matter of making up new people, however. My emphasis on "remaking" throughout this study has been used to invoke the multiple ways that female residents at Edgewood are re-fashioned and re-molded from the moment that they are sent to the campus. These residents may be made first through their referral categories and their psychiatric diagnoses but they are also remade by virtue of living in a place where those classifications take on specific meanings. Moreover, as we have seen in the examination of Guided Group Interaction, female residents actively contribute to their own remaking as they create new labels to describe their position and behavior at Edgewood and as they take up alternative psychiatric identities that appear nowhere in their case records. This does not always proceed as planned, since we have seen that residents tend to be harsh critics of each other and offer narrow space for forgiveness. But perhaps the evidence of remaking at Edgewood can also point us to a more optimistic notion about how these youth will come to inhabit alternative identities over time that have little to do with versions of themselves that appear in their records and more to do with how they see themselves in the world. At the very least, it reminds us that identities can be "practical" rather than ascriptive, changing as we take up membership in new settings and social groups and always open to further revision.[3]

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3. Elizabeth Anderson (2001) describes the notion of "practical identity," a term she borrows from Korsgaard (1996), in an essay about individual preference. Anderson argues that ideas about the rationality of action must be expanded beyond the concept of individual preference; people do not just act as isolated individuals but with others on the basis of shared intentions. She writes, "Practical identification with others does not require any prior acquaintance or relationship. It only requires that we see ourselves as solving a problem by joining forces" (2001:31). Although Anderson's argument is a philosophical one, the notion that identities might be "practical" is useful to my thinking about Edgewood residents.

Limitations

This study has several limitations. First, because I limited myself to one residential treatment center during this project, the data presented here are not claimed to be representative of residential treatment centers in general. The specificity of my data limits the extent to which they might be used as the basis for drawing broader conclusions about residential treatment in the United States. I do think, however, that given the very real confusion about what constitutes residential treatment and who residential treatment centers serve, there is value in providing an intimate portrait of one place in particular and thus an "ethnographic corrective" to the presumed knowledge about residential treatment (Hopper 2003:211).

A second limitation to my study is that it focuses on female youth exclusively and thus does not have comparative data on male youth at Edgewood from which to draw comparisons or conclusions about the distinctiveness of the female experience. Some of my interviews with staff pointed to differences between genders—girls were described as being "more aggressive," and "less afraid to act out" and were said to have more serious histories of abuse and a wider range of mental health problems (Interviews, October 27 and November 3). These observations have been documented elsewhere (Baines and Alder 1996; Timmons-Mitchell et al. 1997; Wasserman et al. 2005). I think it would have been especially revealing to document how GGI works in male cottages in comparison to female cottages so as to better understand how female youth rely on strategies of practice that may be unique when interacting with peers in group therapy.

Finally, this study does not include ethnographic data about the weekend home visits for Edgewood residents. Although I argue that there is tension between the worlds "inside" and "outside" of Edgewood, I did not participate in or observe the lives of residents off-campus and my knowledge is limited to what residents told me about their home visits. Had I gathered data

about the experience of constantly transitioning between Edgewood and home, I think I would have been able to strengthen my argument about "the 'Hood Part 2" and to open up further understanding about the circumstances in which residents are re-immersed upon their discharge.

Directions for Future Research

Additional research on residential treatment and the populations it serves is sorely needed and may take a number of directions. I highlight two areas here that I think are particularly fruitful. First, given that children's perspectives on mental health problems and treatment is an emerging area of study (Carpenter-Song 2009a, 2009b; Floersch 2003; Floersch et al. 2009), I think it is important to explore further how youth in residential treatment conceptualize their problems as well as their experiences taking psychotropic medications. The data I presented in chapters 4 and 5 demonstrate that Edgewood residents have a complex relationship with psychiatry, at once eschewing its diagnoses and adopting them, moralizing against the use of medication and justifying it. To the extent that youth in residential treatment may very well end up as adult consumers in the public mental health system, it is worth exploring their experiences during adolescence and how such experiences may shape their future attitudes and service use.

Second, there is woefully inadequate longitudinal research on youth served in residential treatment and follow-up studies may help to present a more balanced understanding of how youth are best served.[4] In this respect, following youth in residential placements as well as in community-based placements is equally important and moving beyond recidivism as a measure of program success is necessary. In my future work, I will seek to expand on my present analysis by offering a portrait of life experiences after Edgewood.

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4. As a telling example, the New York State Task Force on Transforming Juvenile Justice admits that the most reliable recidivism data are more than ten years old and followed youth released from New York State custody between 1991 and 1995 (Task Force 2009:14).

There are no easy solutions to the challenges and contradictions posed by residential treatment for youth. During the course of my fieldwork, I was often bewildered by the breadth and depth of issues facing Edgewood youth and by the seeming invisibility of places like Edgewood. Given the wave of rhetoric about juvenile justice reform in the United States generally, and in New York in particular, it is unrealistic to think that residential treatment will experience a surge of popularity, at least in the short term. It is also clear, however, that residential placements continue to be utilized by hundreds of youth whose families and communities have failed them in important ways. I have tried to show in this study that living at Edgewood presents a series of opportunities for remaking the self. Such opportunities are not always straightforward, nor do they always occur in entirely positive directions. But by opening up the internal logic of this particular place, we learn more about the intricacy of ties between individuals, institutions, and states, and, in turn, perhaps build a foundation for more informed criticism and debate.

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Appendix A

Diagnostic Criteria for Conduct Disorder
Source: American Psychiatric Association 2000

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:

Aggression to people and animals
(1) often bullies, threatens, or intimidates others
(2) often initiates physical fights
(3) has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
(4) has been physically cruel to people
(5) has been physically cruel to animals
(6) has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
(7) has forced someone into sexual activity

Destruction of property
(8) has deliberately engaged in fire setting with the intention of causing serious damage
(9) has deliberately destroyed others' property (other than by fire setting)

Deceitfulness or theft
(10) has broken into someone else's house, building, or car
(11) often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)
(12) has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

Serious violations of rules
(13) often stays out at night despite parental prohibitions, beginning before age 13 years
(14) has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
(15) is often truant from school, beginning before age 13 years

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

Appendix B
Definitions of the crimes committed by ten Edgewood residents

New York State Penal Law
Definitions

- "Misdemeanor" means an offense, other than a "traffic infraction," for which a sentence to a term of imprisonment in excess of fifteen days may be imposed, but for which a sentence to a term of imprisonment in excess of one year cannot be imposed. Misdemeanors are classified into three categories for the purposes of sentencing: Misdemeanor A, Misdemeanor B and Unclassified Misdemeanor.

- "Felony" means an offense for which a sentence to a term of imprisonment in excess of one year may be imposed. Felonies are classified into five categories for the purposes of sentencing: Class A through Class E.

§ 120.00 Assault in the third degree.
A person is guilty of assault in the third degree when:
1. With intent to cause physical injury to another person, he causes such injury to such person or to a third person; or
2. He recklessly causes physical injury to another person; or
3. With criminal negligence, he causes physical injury to another person by means of a deadly weapon or a dangerous instrument.

Assault in the third degree is a class A misdemeanor.

§ 120.05 Assault in the second degree.
A person is guilty of assault in the second degree when:
1. With intent to cause serious physical injury to another person, he causes such injury to such person or to a third person; or
2. With intent to cause physical injury to another person, he causes such injury to such person or to a third person by means of a deadly weapon or a dangerous instrument; or
3. With intent to prevent a peace officer, a police officer, registered nurse, licensed practical nurse, sanitation enforcement agent, a firefighter, including a firefighter acting as a paramedic or emergency medical technician administering first aid in the course of performance of duty as such firefighter, an emergency medical service paramedic or emergency medical service technician, or medical or related personnel in a hospital emergency department, a city marshal, a traffic enforcement officer or traffic enforcement agent, from performing a lawful duty, by means including releasing or failing to control an animal under circumstances evincing the actor's intent that the animal obstruct the lawful activity of such peace officer, police officer, registered nurse, licensed practical nurse, sanitation enforcement agent, firefighter, paramedic, technician, city marshal, traffic enforcement officer or traffic enforcement agent, he or she causes physical injury to such peace officer, police officer, registered nurse, licensed practical nurse, sanitation enforcement agent, firefighter, paramedic, technician or medical or related personnel in a hospital emergency department, city marshal, traffic enforcement officer or traffic enforcement agent; or

4. He recklessly causes serious physical injury to another person by means of a deadly weapon or a dangerous instrument; or

5. For a purpose other than lawful medical or therapeutic treatment, he intentionally causes stupor, unconsciousness or other physical impairment or injury to another person by administering to him, without his consent, a drug, substance or preparation capable of producing the same; or

6. In the course of and in furtherance of the commission or attempted commission of a felony, other than a felony defined in article one hundred thirty which requires corroboration for conviction, or of immediate flight there from, he, or another participant if there be any, causes physical injury to a person other than one of the participants; or

7. Having been charged with or convicted of a crime and while confined in a correctional facility, as defined in subdivision three of section forty of the correction law, pursuant to such charge or conviction, with intent to cause physical injury to another person, he causes such injury to such person or to a third person; or

8. Being eighteen years old or more and with intent to cause physical injury to a person less than eleven years old, the defendant recklessly causes serious physical injury to such person; or

9. Being eighteen years old or more and with intent to cause physical injury to a person less than seven years old, the defendant causes such injury to such person; or

10. Acting at a place the person knows, or reasonably should know, is on school grounds and with intent to cause physical injury, he or she:
(a) causes such injury to an employee of a school or public school district; or
(b) not being a student of such school or public school district, causes physical injury to another, and such other person is a student of such school who is attending or present for educational purposes. For purposes of this subdivision the term "school grounds" shall have the meaning set forth in subdivision fourteen of section 220.00 of this chapter.

11. With intent to cause physical injury to a train operator, ticket inspector, conductor, signalperson, bus operator or station agent employed by any transit agency, authority or company, public or private, whose operation is authorized by New York state or any of its political subdivisions, a city marshal, a traffic enforcement officer, traffic enforcement agent or sanitation enforcement agent, registered nurse or licensed practical nurse he or she causes physical injury to such train operator, ticket inspector, conductor, signalperson, bus operator or station agent, city marshal, traffic enforcement officer, traffic enforcement agent, registered nurse or licensed practical nurse or sanitation enforcement agent, while such employee is performing an assigned duty on, or directly related to, the operation of a train or bus, or such city marshal, traffic enforcement officer, traffic enforcement agent, registered nurse or licensed practical nurse or sanitation enforcement agent is performing an assigned duty.

12. With intent to cause physical injury to a person who is sixty-five years of age or older, he or she causes such injury to such person, and the actor is more than ten years younger than such person.

Assault in the second degree is a class D felony.

§ 120.07 Gang assault in the first degree.
A person is guilty of gang assault in the first degree when, with intent to cause serious physical injury to another person and when aided by two or more other persons actually present, he causes serious physical injury to such person or to a third person.

Gang assault in the first degree is a class B felony.

§ 120.15 Menacing in the third degree.
A person is guilty of menacing in the third degree when, by physical menace, he or she intentionally places or attempts to place another person in fear of death, imminent serious physical injury or physical injury.

Menacing in the third degree is a class B misdemeanor.

§ 140.10 Criminal trespass in the third degree.
A person is guilty of criminal trespass in the third degree when he knowingly enters or remains unlawfully in a building or upon real property

    (a) which is fenced or otherwise enclosed in a manner designed to exclude intruders; or

    (b) where the building is utilized as an elementary or secondary school or a children's overnight camp as defined in section one thousand three hundred ninety-two of the public health law or a summer day camp as defined in section one thousand three hundred ninety-two of the public health law in violation of conspicuously posted rules or regulations governing entry and use thereof; or

    (c) located within a city with a population in excess of one million and where the building or real property is utilized as an elementary or secondary school in violation of a personally communicated request to leave the premises from a principal, custodian or other person in charge thereof; or

    (d) located outside of a city with a population in excess of one million and where the building or real property is utilized as an elementary or secondary school in violation of a personally communicated request to leave the premises from a principal, custodian, school board member or trustee, or other person in charge thereof; or

    (e) where the building is used as a public housing project in violation of conspicuously posted rules or regulations governing entry and use thereof; or

    (f) where a building is used as a public housing project in violation of a personally communicated request to leave the premises from a housing police officer or other person in charge thereof; or

    (g) where the property consists of a right-of-way or yard of a railroad or rapid transit railroad which has been designated and conspicuously posted as a no-trespass railroad zone, pursuant to section eighty-three-b of the railroad law, by the city or county in which such property is located.

Criminal trespass in the third degree is a class B misdemeanor.

§ 145.10 Criminal mischief in the second degree.
A person is guilty of criminal mischief in the second degree when with intent to damage property of another person, and having no right to do so nor any reasonable ground to believe that he has

such right, he damages property of another person in an amount exceeding one thousand five hundred dollars.

Criminal mischief in the second degree is a class D felony.

§ 145.60 Making graffiti.
1. For purposes of this section, the term "graffiti" shall mean the etching, painting, covering, drawing upon or otherwise placing of a mark upon public or private property with intent to damage such property.
2. No person shall make graffiti of any type on any building, public
or private, or any other property real or personal owned by any person, firm or corporation or any public agency or instrumentality, without the express permission of the owner or operator of said property.

Making graffiti is a class A misdemeanor.

§ 155.25 Petit larceny.
A person is guilty of petit larceny when he steals property.

Petit larceny is a class A misdemeanor.

§ 160.10 Robbery in the second degree.
A person is guilty of robbery in the second degree when he forcibly steals property and when:
　　　1. He is aided by another person actually present; or
　　　2. In the course of the commission of the crime or of immediate flight there from, he or another participant in the crime:
　　　(a) Causes physical injury to any person who is not a participant in the crime; or
　　　(b) Displays what appears to be a pistol, revolver, rifle, shotgun, machine gun or other firearm; or
　　　3. The property consists of a motor vehicle, as defined in section one hundred twenty-five of the vehicle and traffic law.

Robbery in the second degree is a class C felony.

§ 160.05 Robbery in the third degree.
A person is guilty of robbery in the third degree when he forcibly steals property.

Robbery in the third degree is a class D felony

§ 165.40 Criminal possession of stolen property in the fifth degree.
A person is guilty of criminal possession of stolen property in the fifth degree when he knowingly possesses stolen property, with intent to benefit himself or a person other than an owner thereof or to impede the recovery by an owner thereof.

Criminal possession of stolen property in the fifth degree is a class A misdemeanor.

§ 220.03 Criminal possession of a controlled substance in the seventh degree.
A person is guilty of criminal possession of a controlled substance in the seventh degree when he or she knowingly and unlawfully possesses a controlled substance; provided, however, that it shall not be a violation of this section when a person possesses a residual amount of a controlled substance and that residual amount is in or on a hypodermic syringe or hypodermic needle obtained and possessed pursuant to section thirty-three hundred eighty-one of the public health law.

Criminal possession of a controlled substance in the seventh degree is a class A misdemeanor.

§ 221.10 Criminal possession of marihuana in the fifth degree.
A person is guilty of criminal possession of marihuana in the fifth degree when he knowingly and unlawfully possesses:

> 1. marihuana in a public place, as defined in section 240.00 of this chapter, and such marihuana is burning or open to public view; or
> 2. one or more preparations, compounds, mixtures or substances containing marihuana and the preparations, compounds, mixtures or substances are of an aggregate weight of more than twenty-five grams.

Criminal possession of marihuana in the fifth degree is a class B misdemeanor.

Appendix C

<u>Definition of Hard-to-Place</u>
Source: New York Social Services Law § 451

(3) Hard-to-place child means a child, other than a handicapped child:
  (i)   who has not been placed for adoption within six months from the date his or her guardianship and custody were committed to the social services official or the voluntary authorized agency; or
  (ii)   who has not been placed for adoption within six months from the date a previous adoption placement terminated and the child was returned to the care of the social services official or the voluntary authorized agency; or
  (iii)   who meets any of the conditions listed in clauses (a) through (f) of this subparagraph, which the Office of Children and Family Services has identified as constituting a significant obstacle to a child's adoption, notwithstanding that the child has been in the guardianship and custody of the social services official or the voluntary authorized agency for less than six months:
      (a)   the child is one of a group of two siblings (including half-siblings) who are free for adoption and it is considered necessary that the group be placed together pursuant to sections 421.2(e) and 421.18(d) of this Part; and
          (1) at least one of the children is five years old or older; or
          (2) at least one of the children is a member of a minority group which is substantially overrepresented in New York State foster care in relation to the percentage of that group to the State's total population; or
          (3) at least one of the children is otherwise eligible for subsidy in accordance with the provisions of this subdivision;
      (b)   the child is the sibling or half-sibling of a child already adopted and it is considered necessary that such children be placed together pursuant to sections 421.2(e) and 421.18(d) of this Part; and
          (1) the child to be adopted is five years old or older; or
          (2) the child is a member of a minority group which is substantially overrepresented in New York State foster care in relation to the percentage of that group to the State's total population; or
          (3) the sibling or half-sibling already adopted is eligible for subsidy or would have been eligible for subsidy if application had been made at the time of or prior to the adoption;
      (c)   the child is one of a group of three or more siblings (including half-siblings) who are free for adoption and it is considered necessary that the group be placed together pursuant to sections 421.2(e) and 421.18(d) of this Part; or
      (d)   the child is eight years old or older and is a member of a minority group which is substantially overrepresented in New York State foster care in relation to the percentage of that group to the State's total population; or
      (e)   the child is 10 years old or older; or
      (f)   the child is hard to place with parent(s) other than his/her present foster parent(s) because he/she has been in care with the same foster parent(s) for 12 months or more prior to the signing of the adoption placement agreement by such foster

parent(s) and has developed a strong attachment to his/her foster parent(s) while in such care and separation from the foster parent(s) would adversely affect the child's development.

Appendix D

Positive Peer Culture Labels and Definitions
Source: Vorrath and Brendtro (2007:43-47)

Low Self Image	Often feels put down or of little self worth	• Feels unlucky, a loser, rejected, mistreated; feels sorry for himself; has no confidence he can be of value to others • Worries that something is wrong with him, feels inadequate, thinks he is good for nothing, is afraid others will find out "how bad I really am" • Distrusts others, feels they are against him and want to hurt him, feels he must defend himself from others • Is uncomfortable when people look at him or speak to him, can't face up to people confidently and look them in the eyes • Is insecure with "superior" people, doesn't feel good enough to be accepted by others except those who also feel poorly about themselves
Inconsiderate of others	Does things that are damaging to others	• Does things that hurt people, enjoys putting people down • Acts selfishly, doesn't care about the needs or feelings of others • Seeks to build self up by manipulating others for his own purposes • Takes advantage of weaker persons and those with problems • Won't help other people except, possibly, if they are members of his own family or circle of friends
Inconsiderate of self	Does things that are damaging to self	• Puts self down, brings anger and ridicule on self, does things that hurt self • Acts as though he doesn't want to improve self or solve problems • Tries to explain away his problems, runs away from problems • Doesn't want others to point out his problems or talk about them but resists help with problems
Authority problem	Does not want to be managed by anyone	• Views authority as an enemy camp "out to get him" • Resents anybody telling him what to do,

		• doesn't not readily accept advice from either adults or peers • Can't get along with those in authority, gets into big confrontations with authority figures often over minor matters • Does not respond well to parental control or supervision • Tries to outmaneuver authority figures, circumventing or manipulating them if possible
Misleads others	Draws others into negative behavior	• Seeks status by being a negative or delinquent leader • Gives support to the negative or delinquent actions of others • Misuses others to achieve his own goals, getting them to do his "dirty work" • Wants others to be in trouble with him, afraid of being separate • If others follow him and get in trouble, feels that it is their problem and not his responsibility
Easily misled	Is drawn into negative behavior	• Can't make his own decisions and is easily controlled by stronger persons • Can't stand up for what he believes, even when he knows he is right • Is easily talked into committing delinquent acts in order to please or impress others • Behavior varies from good to bad, according to influence from those with whom he associates • Let's people misuse him, is willing to be somebody else's flunky
Aggravates others	Treats people in negative, hostile ways	• Makes fun of others tries to embarrass them and make them feel low • Seeks attention in negative ways, irritates or annoys people • Makes subtle threats in word or manner • Challenges, provokes, or hassles others • Intimidates, bullies, pushes people around
Easily angered	Is often irritated or provoked or has tantrums	• Frequently becomes upset or explosive but may try to excuse such behavior as naturally "having a bad temper" • Easily frustrated, unable to accept failure

		or disappointments
		• Responds to the slightest challenge or provocation, thus making other peoples' problems his own
		• So sensitive about himself that he cannot stand criticism or disagreement with his ideas
		• Easily upset if someone shouts at him, points a finger at him, touches him, or shows any negative feelings toward him
Stealing	Takes things that belong to others	• Thinks it's alright to steal if you are sneaky enough to not get caught
		• Doesn't respect others and is willing to hurt another person to get what he wants
		• Steals to prove he is big and important or to prove he is "slick" enough to get away with it
		• Steals because he is afraid peers will think he is weak or a chicken if he doesn't
		• Doesn't have confidence that he could get things by his own effort
Alcohol or drug problem	Misuses substances that could hurt self	• Afraid he won't have friends if he doesn't join them in drugs or drinking
		• Thinks drugs are cool, tries to impress others with his drug knowledge or experience
		• Uses the fact that many adults abuse drugs (such as alcohol) as an excuse for his involvement
		• Can't really be happy without being high, can't face his problems without a crutch
		• Acts as though he doesn't care about damaging or destroying self
Lying	Cannot be trusted to tell the truth	• Tells stories because he thinks others will like him better
		• Likes to live in a make-believe fantasy world
		• Is afraid of having his mistakes discovered and so lies to cover up. May even make up false problems to hide real ones.
		• Has told so many lies that he may lie even when there is no apparent need to lie
		• Twists the truth to create a false

		impression but doesn't see this as lying
Fronting	Puts on an act rather than be real	• Needs to appear big in the eyes of others, always needs to try to prove himself • Bluffs and cons people, thinks loudness and slick talk are better than reason • Acts superior, always has to be right, argues, needs to be best in everything, and resents being beaten • Clowns or shows off to get attention • Plays a role to keep from having to show his real feelings to others

Appendix E

<u>Diagnostic criteria for Oppositional Defiant Disorder</u>
Source: American Psychiatric Association 2000

A. A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:
(1) often loses temper
(2) often argues with adults
(3) often actively defies or refuses to comply with adults' requests or rules
(4) often deliberately annoys people
(5) often blames others for his or her mistakes or misbehavior
(6) is often touchy or easily annoyed by others
(7) is often angry and resentful
(8) is often spiteful or vindictive

Note: Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder.

D. Criteria are not met for Conduct Disorder, and, if the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

Appendix F

Labels from Guided Group Interaction in Hamilton Cottage and Thayer Cottage

Problems Related to Campus Life	
1.	AWOLing
2.	Bedtime routine
3.	Being late
4.	Destroying property
5.	Disturbing the cottage
6.	Going Out of Program
7.	Going to the hospital
8.	Having a phone
9.	Having to be talked to more than once
10.	Hygiene (personal or room care)
11.	Lending and borrowing
12.	Making the cottage look bad
13.	Messing up cottage program
14.	Not doing your chore properly
15.	Not following cottage program
16.	Not following directions first time given
17.	Not following rules
18.	Not going to class
19.	Not going home immediately on your home pass
20.	Not keeping cottage business inside the cottage
21.	Not letting staff do its job
22.	Not listening
23.	Not respecting people's space
24.	Not returning from your home pass or day pass on time
25.	Not sleeping at night
26.	Poor school citizenship
27.	Refusing your medications
28.	Room visiting
29.	Slamming the door
30.	Taking too long in the shower
31.	Time management
32.	"Turning it up" (i.e., having a tantrum)
33.	Walking away from the group

Emotional/Attitudinal Problems	
34.	Acting childish
35.	Attitude problem
36.	Being a hypocrite
37.	Being defiant
38.	Being depressed

39.	Being fake/phony
40.	Being irresponsible
41.	Being naïve
42.	Being rude
43.	Being sneaky
44.	Being spiteful
45.	Easily angered
46.	Easily frustrated
47.	Easily influenced
48.	Not expressing how you feel

Problems Related to Sense of Self	
49.	Being too hard on myself/yourself
50.	Caring about people who don't care about me/you
51.	Caring about people who don't care about themselves
52.	Caring about people I/you don't know
53.	Cutting myself/yourself (i.e., self-harm)
54.	Having low self-esteem
55.	Letting people control my/your feelings
56.	Letting people get to me/you
57.	Letting things get to me/you
58.	Not being my/your own person
59.	Not caring about going home
60.	Not caring about myself/yourself
61.	Not dealing with my/your frustrations
62.	Not focusing on myself/yourself/Not working on myself/yourself
63.	Not minding my/your own business
64.	Not respecting myself/yourself
65.	Not staying to myself/yourself
66.	Stressing myself/yourself out
67.	Thinking about too much

Problems with Negative Activity	
68.	Being part of the problem/Feeding into negativity
69.	Engaging in negativity
70.	Hanging around negativity/Not avoiding negativity
71.	Not handling the situation in a better way
72.	Not knowing when to stop
73.	Not making better decisions
74.	Not thinking before I/you act
75.	Not using coping skills
76.	Not using my intellect to avoid confrontation
77.	Not walking away

Problems with Fighting/Arguing	
78.	Arguing
79.	Attempting to fight
80.	Fighting
81.	Going Tit-for-Tat
82.	Instigating peers/Triggering others
83.	Putting your hands on staff
84.	Putting your hands on other people's kids
85.	Spitting on people
86.	Starting trouble
87.	Threatening people

Problems with Peer and Staff Relationships	
88.	Calling people out their name
89.	[Being] Disrespectful
90.	Disrespecting peers
91.	Disrespecting staff
92.	Getting staff in trouble
93.	Giving bad advice
94.	Hurting peers [being hurtful]
95.	Inconsiderate to peers and self
96.	Misleading self and others
97.	Not being a good friend
98.	Not caring about people's feelings
99.	Not confronting your peers
100.	Not respecting adult figures
101.	Not taking advice from peers or staff
102.	Putting yourself or others down
103.	Reaction to authority
104.	Trashing peers (i.e., speaking badly about peers)

Problems with Progress	
105.	Falling off track
106.	Giving up
107.	No change, no growth
108.	Not accepting criticism/confrontation
109.	Not accepting help/not asking for help
110.	Not caring
111.	Not doing what I am/you are supposed to be doing
112.	Not talking to somebody
113.	Not trying hard enough/Not trying to change
114.	Not trying to leave [be discharged]

Problems with Sexual Activity and Substance Abuse	
115.	Inappropriate behavior
116.	Sagging
117.	Sexually acting out problem
118.	Smoking problem
119.	Substance abuse problem

Miscellaneous Problems	
120.	Being a follower
121.	Blowing stuff out of proportion/Making a movie out of everything
122.	Complaining too much
123.	Cursing
124.	Dishing it out but not taking it
125.	Giving too much feedback
126.	Gossiping
127.	Horseplaying/Playing too much
128.	Indirect comments
129.	Inconsistent behavior
130.	Labeling the same thing every GGI
131.	Laughing in GGI
132.	Loud tone
133.	Lying
134.	Making excuses
135.	Not acting your own age
136.	Not calming down
137.	Not controlling your anger/self-control
138.	Not showing patience
139.	Not staying true to your diet
140.	Poor body gestures
141.	Putting on an act
142.	Smart comments
143.	Stealing
144.	Taking everything as a joke
145.	Trying to control things
146.	Trying to fit in too much

147.	**No issues to report**