Association of Children's Residential & Community Services
Home to the Building Bridges Initiative
(877)332-ACRC ksisson@togetherthevoice.org www.togetherthevoice.org

Redefining Residential: The Use of Individual Therapy in Residential Interventions

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This is the nineteenth in a series of papers by the Association of Children's Residential and Community services (ACRC) addressing critical issues facing residential programs. The purpose of the papers is to stimulate dialogue and self-examination among organizations, stakeholders, and the field. ACRC is the longest standing association focused on the needs of children and youth who require a residential program, and their families and communities.

A core component of residential programming has typically been the provision of individual therapy. Rooted in psychodynamic theory and practice, the development of a therapeutic alliance through psychotherapy has been regarded as a key driver to successful treatment, generating the insight, skill development and healing that manifest in improved functioning upon return to the community (Stanek, 2025). Even as other mediators of successful outcomes have been identified (e.g. family driven care, community supports for transition) (Blau, et. al. 2014), individual therapy has remained a cornerstone in residential programs.

The role, nature, and scope of individual therapy in residential has been impacted by changes in funding stream expectations, payer policies, and residential practices. Shorter lengths of stay, family-driven and community integrated practice raise questions regarding the role and purpose of individual therapy. Traditionally grounded in the idea of psychotherapy as a "talking cure", individual therapy in practice has variably taken the form of counseling, an evidence based manualized approach, or even case management. To gauge how residential programs are currently utilizing individual therapy, ACRC conducted a survey of its members in 2025.

This paper examines the use of individual therapy in residential programs. It discusses common factors influencing efficacy, summarizes the survey results and the emergent role of the individual therapist, addresses particularities in residential programs, and derives implications for practice.

COMMON FACTORS

Historically, the various specific forms of individual psychotherapy, practiced with specific client populations, have been shown to be efficacious. As an example, cognitive behavioral therapy has been validated as an effective treatment for anxiety, depression, posttraumatic stress disorder, and other conditions in youth and adults (Kodal *et al*., 2018; Weersing, *et al.*, 2018; Jensen *et al.*, 2014). More recently, however, research into efficacy has focused on common factors that unify therapy, and some researchers have failed to find significant differences among specific modalities of psychotherapy, sometimes going as far as to question whether modality even matters (e.g., Miller, Wampold, & Varhely, 2008). While the research generally finds psychotherapy beneficial, it also suggests that key common factors are required to optimize the outcomes of individual therapy, regardless of theoretical model or setting. These factors, which involve relational, environmental, and cultural attunement, are: (Wampold, 2015):

a) establishment of an initial bond;
b) a human connection with an empathic and caring individual in an emotionally charged, confiding relationship;
c) a healing environment that supports the client's belief that the therapist can help;

d) a culturally attuned and psychologically sound rationale for treatment that is communicated to and accepted by the client; and
e) a process, set of procedures or rituals that includes active participation by both therapist and client and that "leads the client to enact something that is positive, helpful, or adaptive (Laska, Gurman, and Wampold, 2014, pg. 469)

It should be noted that common factors research is a work in progress. The factors noted make sense and are important components of therapeutic interventions but haven't been conclusively established in the literature as mechanisms of change. Nonetheless, residential programs are typically designed around these types of factors, which is reflected by the 2025 survey.

RESULTS OF THE SURVEY

The survey was completed by 128 agency members of ACRC. It showed that essentially all organizations are providing individual therapy as part of their treatment design, whether or not mandated by funders, at a frequency of 1-3 hours per week. The therapists often also provide therapy for the family. Five themes emerged:

- **Individual Therapy as a Core Component**: Nearly all agencies emphasized the importance of individual therapy, typically provided for at least one hour per week, though often adjusted based on youth needs (e.g., split into shorter sessions).
- **Integration with Other Therapeutic Modalities**: Providers frequently mentioned combining individual therapy with group therapy, family therapy, and specialized approaches like CBT, DBT, EMDR, art therapy, and animal-assisted therapy.
- **Therapists' Roles Beyond Sessions**: Therapists are often embedded in the daily milieu, providing informal support, crisis intervention, mentoring of staff, and case management, highlighting their broader role in creating a therapeutic web.
- **Trauma-Informed and Individualized Care**: Organizations stressed tailoring therapy to each youth's trauma history and engagement style, noting challenges with traditional "talk therapy" and the need for creative, flexible approaches.
- **Systemic and Funding Challenges**: Several responses pointed to barriers such as low Medicaid reimbursement rates, bundled payment models, and staffing limitations that affect the ability to provide therapy based on actual client need.

These findings reflect that the provision of individual therapy tends to incorporate specific program factors and reflect efforts to implement common factors identified in the research.

INDIVIDUAL THERAPY IN RESIDENTIAL- PARTICULARITIES

A Changing Role

By the time a youth is referred to residential, it is likely that they have experienced multiple unsuccessful efforts of individual therapy in less restrictive settings. Youth in residential typically present with a history of refraction to prior interventions, and with complex diagnostic presentations (Krishnan, 2016); have high degrees of exposure to traumatizing and otherwise adverse childhood experiences (ACEs) (Bettmann, 2011); and may also be more likely to have salient cultural needs, including being of ethnic, sexual, or gender minorities (Glick, 2016). It has been well-established that trauma exposure for residentially placed youth is more extensive than in outpatient populations, with a graded correlation between trauma exposure and emotional and behavioral challenges (Briggs et al., 2012; Foltz et al., 2013). The cumulative effects of trauma can mimic primary symptom presentations of the diagnoses commonly assigned to youth

(American Psychological Association, 2013), all of which are also significantly correlated with Adverse Childhood Experiences (Anda, et. al.2018), confounding diagnostic related interventions.

This reality may increase the challenges of establishing the common factors noted above in individual therapy but does not prevent doing so through the availability of other relational resources. In fact, the higher degree of intensity and consistency of therapeutic services in residential programs offers a unique opportunity for a truly transformative therapeutic experience, and unique opportunities for therapists to collaborate with other youth care professionals (Brendtro, 1969). The survey results suggest a commensurate changing role of individual therapy and the individual therapist, customized to these unique needs of the youth served and the multidisciplinary approach typical of residential programs.

Therapeutic Relationships

Residential practice involves establishing and/or affirming relationships with multiple individuals beyond the therapist, including direct care and managerial staff, parents, peer support specialists, community members, etc. Youth relationships with these adults can cultivate and strengthen their coping abilities and extend the therapeutic relationship into a therapeutic web (Campbell, 2018), reducing reliance on the presence of the therapist. Direct care staff in particular are key in this process. The common factors noted above do not have to be reserved exclusively for the individual therapy interaction but rather can be facilitated by multiple relationships throughout day-to-day programming, leading to positive identifications and therapeutic gain.

Neuroscientific research that shows that brief momentary interactions can bring down a person's stress arousal rate suggests that many therapeutic moments throughout the day are more likely to impact the individual's overall growth and healing than typical hour-long sessions (Perry, 2020). While "secure attachment within the therapeutic relationship serves as the matrix for positive change" (Cozolino, 2016, p. 19), the extension of this process to the multiple individuals interacting with the youth offers a relationally rich opportunity for youth in residential programs to develop self-regulation, relationship, and thinking skills. Since many other staff develop relationships with the youth, the individual therapist can serve as a relational coach- the expert in relationships- whose role beyond providing individual therapy is to understand the dynamics of the relationships the youth have with family and with staff, and to support the building of key relational skills. The ability to facilitate short increments of relationship-building throughout the day with all staff and with parents, through dosing and spacing (Perry, 2020), is a unique opportunity in residential programs. The therapist can assume a critical role in helping to guide the nature and tone of this relational web. Some survey respondents have moved in this direction:

> *"Our therapists have a significant role in helping create a therapeutic environment beyond their 'office'. They are in a constant consulting and mentoring role with all direct care staff. They bridge child and family needs. Beyond the formal individual therapy they have multiple check ins with kids and provide support when suicide precautions need to be implemented."*
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> *"Our therapists are embedded in milieu teams and participate in daily milieu structure in addition to providing therapy sessions. "*
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> *"Individual therapy is essential in residential treatment however there are many other therapies that are coupled with individual therapy that make residential treatment effective. 1 hour a week of individual therapy for a child in residential treatment is not the game changer, it is the culmination of a 24/7 trauma informed environment, positive relationships with staff, skill building, and trauma recovery."*

"Talk Therapy"

A key aspect of individual "talk therapy"- "having to make our experiences comprehensible to another person …" (Cozolino, 2016, p. 57)- in itself is a stressor, as are the youth's specific adaptations in the context of the therapy relationship, since "the brain uses past relationships to shape our perceptions of the thoughts, feelings, and intentions of others" (Cozolino, 2016, p. 6). If/when the individual therapy process elicits high states of stress arousal "the brain area responsible for expressive speech becomes inhibited" (Cozolino, 2016, p. 14) and the therapy process can become confounded. This potential is exacerbated for youth raised in indigenous or otherwise more collectivist cultures whose attachment "anchors" in the brain are less dyadic (as typically practiced in individual therapy), making the individual relationship less important than the collective (Perry, 2025). Additionally, developmental issues such as attention span, impulse control, cognitive functioning, and interpersonal skills are all examples of dimensions that may require a modification to the delivery and frequency of formal individual therapy services. Another respondent commented on the limitations of "talk therapy":

> "*We have noticed over the past 5 years or more that less youth … engage in typical talk therapy. We also notice that youth in residential treatment have a difficult time sitting for long periods of time. We aim for 30-minute sessions but recognize that may look different depending on the youth we are working with. We have also adopted different methods such as play and art therapy techniques to engage them with less talking. Additionally, we have found that having resources outside of the residential setting leads to an increase in engagement in individual therapy. This might be done by engaging family members who have struggled to engage in the past, looking at community members who the youth has connected with in the past or connecting with an outside agency who connects youth with a "forever person". We have also increased the number of therapeutic groups that are offered, and we have the opportunity to build off of those groups in individual therapy."*

Along these lines, the survey results also show that residential programs are implementing expanded roles for therapists beyond individual "talk therapy". These include providing group and family therapy, case management, coaching, and linking individual therapy with therapeutic efforts in the community. While such expanded roles can complicate boundary definition for the therapist and youth (Stanek, 2025), when explicitly addressed by the program, for example in program specific guidelines, they nonetheless represent promising avenues for providing a predictable and coherent therapeutic experience for the youth and family and for extending opportunities to assist with skill development and healing to all people comprising the therapeutic web (Campbell, 2018).

IMPLICATIONS

As the survey results indicate, the nature of individual therapy in residential programming is changing, moving away from the outpatient one hour per week model, though that is still common, to becoming more customized to the unique needs of the youth using the considerable resources of a multidisciplinary team approach. A program could have an incredible group of therapists, but if their work is not coordinated with that of the others in the relational web available to the youth, it is unlikely to yield maximum impact. A more deliberate application of this important modality in residential is indicated and already underway in some programs. Specific recommendations:

- Utilize a transdiagnostic approach, viewing youth through a lens focusing less on a diagnosis, but more on the constellation of presenting clinical issues. A transdiagnostic approach creates a "consolidated set of interventions aimed to efficiently and effectively treat multiple disorders or problem sets simultaneously" (Chu, 2012, p. 1).

- Establish or strengthen a multidisciplinary approach in which all adults and parents are coached and mentored in therapeutic presence, interpersonal skills, and the common factors, utilizing therapy staff as mentors and guides to the process. Collaborate with all stakeholders to critically define and assess "success" (Boston, 1989).
- Link services in the program, the home, and the community, to facilitate a therapeutic web that is culturally attuned and conveys an understanding of the rationale and process of treatment that is known to, accepted by and co-designed with the youth (Campbell, 2018).
- Implement principles of family and youth driven care, particularly youth and family voice and choice, as well as culturally and linguistically competent, and community linked services and supports. Offer opportunities for the therapist to model and teach evidence informed, neurodevelopmentally aligned practices (Lieberman, et. al. 2020) that extend the common factors into a therapeutic web of individuals supporting the youth and family.
- Clearly delineate the role of the therapist, to include a clinical leadership role in the therapeutic web along with provision of individual therapy. Establish boundary definition guidelines that uphold professional ethical codes while facilitating an expanded role.
- Critically evaluate youth and family response to therapy and to the overall treatment plan, and integrate information gained from assessments, including assessments completed after discharge, into ongoing improvement of individual therapy practice.

CONCLUSION

Residential programs support young people who are navigating some of the most complex needs and circumstances in our communities across the world. As such they are uniquely positioned to collect, understand, and apply data to further the effectiveness of individual therapy in residential programs. ACRC encourages residential providers to continue to examine this important practice and make changes and improvements in keeping with the research and science that will improve the lives of youth and families.

For more information, please contact ACRC at info@togetherthevoice.org

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