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Jessica Rose Donohue
Women Among Men: The
Experiences of Female Staff
in Residential Facilities for
Adolescent Males

ABSTRACT

This exploratory study was undertaken to examine women's experiences working in residential treatment facilities for adolescent males, and to better understand the existing gender dynamics in this particular setting. The research questions guiding this study were: How do gender stereotypes affect women's experiences working in residential treatment with adolescent males? How do women feel that they are perceived by co-workers and residents?

Thirteen women participated in this qualitative study. Six women performed clinical roles, three were direct care staff, three were case managers, and one was a teacher. Through structured interviews, the participants provided narratives about their agency/job requirements or responsibilities, relationship dynamics with co-workers, relationship dynamics with residents, and their own perceptions of their gender and racial identities.

The study revealed that residential treatment facilities for adolescent males are workplaces where gender inequality has persisted, with policies and expectations being enforced unequally. Women are expected to fulfill stereotypical gender roles, and reported having to disprove gender stereotypes in order to be viewed as competent workers. Gender and sexuality are elements of the residential milieu that demand closer attention in order to improve women's workplace experiences and to guarantee the integrity of the therapeutic environment.

WOMEN AMONG MEN: THE EXPERIENCES OF FEMALE STAFF IN
RESIDENTIAL FACILITIES FOR ADOLESCENT MALES

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2009

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CHAPTER I

INTRODUCTION

The residential treatment facility for adolescent males is a therapeutic environment unlike any other. Designed to house youth with extreme emotional or behavioral issues who have unsuccessfully passed through less restrictive settings, residential facilities provide intensive treatment and round the clock care and supervision (Nickerson, Brooks, Colby, Rickert, & Salamone, 2006; Stein, 1995). Because of the severe emotional states of the adolescents, already in a tumultuous developmental period, their behavior can be unpredictable and sometimes highly aggressive (Miller & Georges, 2006; Pazaratz, 2003). The adults who help them work on their issues are clinicians and direct care staff, who often act as surrogate parents to these adolescents. Staff must rely largely on intuition and their own life experiences in structuring the residential environment (Fyhr, 2001), as little training beyond safety or regulations is typically offered (D. Burton, personal communication, August 15, 2008). To maintain a space that adolescents feel is physically and emotionally safe, it is of utmost importance for staff to maintain open communication with each other and model respectful, healthy relationships.

Women working in male-dominated fields are often confronted with sexism, manifested in attitudes and stereotypes prescribed to women, gendered assignment of tasks, and sexual harassment (Coburn, 1997; Cohn, 1996; Heilman, 2001; Nelson, 1992). While women's experiences in traditionally male-dominated fields have earned attention

from researchers, a thorough review of the literature yields no research on the residential treatment setting as a gendered workplace. Female staff reside in this neglected intersection, where women must negotiate a male-dominated workplace while maintaining a therapeutic, safe environment for the adolescents they serve.

This study will examine women's experiences working in residential treatment facilities with adolescent males, thereby contributing to the knowledge base for both the effectiveness of residential treatment, and women's workplace experiences. The voices of female staff may serve as an untapped resource in improving how residential treatment is conceptualized and delivered. It is the intent of this study to give voice to a particular group of working women while gaining an understanding of an unstudied aspect of residential treatment. The study will be guided by the research questions: How do gender stereotypes affect women's experiences working in residential treatment with adolescent males? How do women feel that they are perceived by co-workers and residents?

CHAPTER II

LITERATURE REVIEW

This chapter will illustrate why women's experiences working in residential treatment facilities with adolescent males are important to recognize and understand. While this project connects the previously researched topics of residential treatment facilities and women's workplace experiences, nearly all the research has approached these subjects independently. Therefore, this author will review the literature separately, and then will highlight the importance of connecting these previously discrete bodies of research. The chapter will begin by focusing on the goals, values, and dynamics of residential treatment facilities. Adolescent development will be discussed in the context of residential treatment, followed by the role of staff in this milieu. The final section is dedicated to women's experiences in male-dominated workplaces, and some of the struggles women face in such work environments.

Residential Treatment

Residential treatment facilities in the United States serve as surrogate homes for an estimated 250,000 children with severe behavioral and emotional issues (Bilchik, 2005). According to the Child Welfare League of America (2007), the primary purpose of residential care "is to address the unique needs of children and youth who require more intensive services than a family setting can provide" (p.1). Residential treatment facilities are designed to be a last stop for severely disturbed adolescents who have generally been unsuccessful in less restrictive educational and therapeutic living

placements, and who require intensive treatment (Foltz, 2004; Pazaratz, 2003).

Residential care is thought of as a treatment of last resort, due to its highly restrictive nature and the seclusion of the children from their families and communities (Frensch & Cameron, 2002; Nickerson et al., 2006). Children are placed in residential care either by parents or state agencies to receive structured, monitored opportunities that will help them achieve behavioral and intellectual learning and maturity.

The residential treatment center is a unique therapeutic setting in that it maintains nearly complete control over the environment of a child, and accepts absolute responsibility for the care of the child (Stein, 1995). Researchers (Handwerk et al., 2006; Leichtman, 2006; Lyman & Campbell, 1996) agree that it is difficult to define “treatment” in “residential treatment,” as programs vary tremendously and the concept is difficult to articulate. Residential treatment differs from other treatment settings in a number of ways. Significantly more intensive than outpatient therapy, residential treatment affords therapists and counselors the opportunity to intervene and address issues as they arise, when the context is clear and the affect is present. For severely disturbed youth, this is often much more useful than trying to work on critical events several days later at a scheduled appointment time. The residential treatment environment also differs in important ways from inpatient treatment or psychiatric hospitals. Inpatient settings generally follow a medical model of care, characterized by symptoms, diagnoses, and treatment by a medical staff.

The orientation followed by residential treatment is one of parenting, where children stay in homes or cottages and are guided in the negotiation of developmental tasks (Leichtman, 2006; Lyman & Campbell, 1996; Stein, 1995). Not only is the

treatment center responsible for the clinical treatment of the child, as mental health clinics and family guidance centers are, but they are also responsible for the essential day-to-day needs of children. The provision of adequate and sufficient food, clothing, shelter, education, hygiene and health care often requires even more time, energy and planning than the treatment portion of the facility's services (Stein, 1995). The milieu is crafted so that the community actually becomes the therapeutic tool. Trieschman, Whittaker, and Brendtro (1969) referred to the hours spent in the milieu, outside of the time devoted to formal therapies, as "the other 23 hours" (p.1.). Leichtman (2006) states,

Because the problems that lead to out of home placements are not typically discrete, episodic symptoms, but rather pathology that is woven into the fabric of lives, residential treatment rests on the assumption that helping children negotiate [daily] tasks effectively is not merely an adjunct to more sophisticated forms of therapy, but rather a cornerstone of treatment. (p. 287)

The Residents: Where They Have Been and What They Need

The youth served in residential treatment come from an extreme range of backgrounds, racially, ethnically, socioeconomically, and geographically. According to the National Survey by the American Association of Children's Residential Treatment Centers (2000), the most common reasons for admission to residential treatment are severe emotional disturbance, aggressive/violent behaviors, family/school/community problems, and abuse. Typically these youngsters have been involved with social service, mental health, juvenile justice, and special education services prior to admission. Some have severely traumatic histories and have been shuttled between numerous placements, and most seem to come from highly dysfunctional and unstable families (Lyman & Campbell, 1996; Stein, 1995). They also often have a low tolerance for frustration, poor

reality testing, and an inability to understand the nature of cause and effect (Pazaratz, 2003). Because of these factors, it's not unusual for adolescents in residential treatment to harbor extreme anger, or to lash out verbally or physically (Miller & Georges, 2006; Pazaratz, 2003; Stein, 1995). Trieschman et al. (1969) describe many of the behaviors exhibited by these youngsters as "deviant, dangerous, and age-inappropriate" (p. 4).

There is no universal way of operating a residential treatment facility, and agencies follow a variety of values, theories and treatment modalities. However, Moses (2000a) states that the core belief that unites different treatment approaches at different residential treatment facilities is that benign human relationships create an environment of safety and growth. All interactions in the milieu are presumed to have the therapeutic potential to be corrective emotional experiences for the youngsters (Moses, 2000a; Moses, 2000b). The therapeutic milieu is intended to provide optimal conditions for growth and development, so that children who have experienced extreme developmental deficits may move towards developmentally appropriate levels (Bettelheim, 1949; Moses, 2000a).

The Staff: Responsibilities and Challenges

According to Bettelheim (1949), residential treatment is indicated for some children whose original home environment "fails to provide them with at least one consistent relationship in which they experience security" (p. 58). As a 24-hour-a-day treatment environment, and one that caters to youth with such extreme needs, clinicians and direct care staff have different relationships with the children than do staff of other treatment facilities, like outpatient centers or schools. The primary responsibility of residential staff, therefore, is to maintain a physically and emotionally safe and

predictable environment in which they are “transmitting social and psychologically sound values and teaching reciprocity of emotional transactions” (Moses, 2000a, p. 474). The reality of residential care is that some of the youth need these facilities to raise them. While many adolescents have experienced harmful relationships with adults, Foltz (2004) says “these troubled children remain very receptive, albeit cautious, to positive, caring relationships” (p.15).

In outpatient settings, clinicians and social workers are key figures in children’s treatment. In residential treatment facilities, clinical staff similarly play an instrumental role, providing oversight, direction, and specific therapies (Lyman & Campbell, 1996). The critical difference in residential treatment, however, is the presence of youth care workers, sometimes referred to as youth workers, direct care staff (Pazaratz, 2003), line staff (Lyman & Campbell, 1996), or child care counselors (Stein, 1995), who represent the strongest force in carrying out the treatment in the residential program. They are considered to be the main teachers, implementing the therapeutic milieu, daily routines, and protocols (Lyman & Campbell, 1996; Moses, 2000a; Treischman et al., 1969). Typically youth care workers staff three eight-hour shifts with more than one staff on duty during busy times, like evenings, weekends, and during the summer (Stein, 1995).

Direct care staff come to the work with varying backgrounds and training, but are crucial to children’s treatment as agents of change (Pazaratz, 2003). According to Stein (1995), they spend around 168 hours per week with the children, whereas those with professional training—psychiatrists, social workers, and psychologists—may only spend minutes or hours with the children each week. Moses (2000a) argues that child care workers, because they have the most direct contact with children in residence, may often

be more influential than therapists and “may have the greatest opportunity to make a lasting impression” (p. 474).

Residential staff are asked to act as substitute parents, “fulfilling parent-like roles without pretending it to be an equivalent to family life” (Redl, 1959, p. 726). Compared to other staff in the facility, direct care staff often have very little training or education for this position, and base their working strategies largely on their own life experience, intuition, values, and common sense (Fyhr, 2001; Lyman & Campbell, 1996). They fulfill therapeutic and parental roles, and help adolescents to negotiate their daily functions. Their goal is to maintain a structured environment that focuses on skills that need to be learned in order to develop pro-social behaviors and improved family and peer relationships. One of the central objectives is to maintain a physically and emotionally safe and predictable environment (Bettelheim, 1949). While there is no step-by-step method of managing disturbed adolescents, staff must have some skills in behavior management, limit setting, effective communication, problem solving, monitoring of progress, and facilitation of pro-social attitudes and activities (Pazaratz, 2003).

Together, the professionally trained staff and the direct care staff represent the adults who work to help adolescents in residential treatment. The nature of the work in treatment facilities for disturbed adolescents is hectic, demanding, and exhausting, both physically and emotionally, for all those involved. As in parenting, staff members must coordinate innumerable small decisions in the course of a day, complicated by the fact that troubled adolescents are prone to testing limits and playing one staff member against another (Bettelheim, 1949; Leichtman, 2006; Treischman et al., 1969). Their jobs require them to police the youth’s actions and provide compassionate interventions at the same

time, while maintaining a treatment environment that is positive, nurturing and upbeat rather than punitive or repressive (Lyman & Campbell, 1996; Moses, 2000a). Amidst the chaos that sometimes accompanies working with emotionally disturbed adolescents, staff members are expected to maintain an emotionally stable environment. According to Pazaratz (2003), the expectation is for staff to respond reflectively rather than reactively to adolescents in their care, as adolescents will respond positively when they perceive the environment to be a safe and meaningful place. Additionally, interventions based on harsh confrontation may replicate abusive environments the adolescents have previously experienced (Prescott, 2001). This means that, ideally, workers communicate openly and respectfully with each other, role modeling pro-social problem-solving skills and making decisions cooperatively and consistently with the other staff (Stein, 1995).

Researchers have taken note that, although the role of direct care workers is critical in the milieu, it is often viewed as a “lesser breed” – a para-professional, non-specialist whose contributions are considered less significant than that of the social worker or the psychiatrist (Bettelheim, 1966; Moses, 2000b). Shiendling (1999) asserts, “The philosophy set forth by program administrators, and the therapeutic interventions designed by clinicians can either be fulfilled or derailed by the actions of the front-line staff” (p. 20). Leichtman (2006) emphasizes that clinicians and administrators must remember that childcare staff play a central role in the treatment of adolescents in residential care, and that “the therapeutic community is the continuous creation of and by all staff members” (Bettelheim, 1966, p. 696). Honest and consistent communication between all members of the treatment environment, including residential, clinical,

educational, and recreational staff, is crucial in ensuring the safety of the children in residential programs (Caldwell & Rejino, 1993).

Support from supervisors and co-workers, and adequate training and supervision are particularly important in maintaining satisfaction and positive outcomes in child welfare work (Caldwell & Rejino, 1993; Leichtman, 2006; Stalker, Mandell, Frensch, Harvey & Wright, 2007). Lyman and Campbell (1996) and Pazaratz (2003) argue that a strong in-service training program is essential to ensuring that the staff have the skills and confidence necessary to function effectively, the knowledge to understand why youth act out, and an adequate awareness of their developmental needs. Nonetheless, little training beyond safety or regulations is typically offered to staff in residential facilities (D. Burton, personal communication, August 15, 2008). Programs often devote more of their time and resources to directly meeting clients' needs than to staff training. Shiendling (1999) argues that providing quality training and professional development must be regarded within the organization as high a priority as planning treatment interventions with children.

Normal Adolescent Development

Adolescence is a tumultuous period in normal teens' development. From middle school through high school, adolescents experience a time of great transition, physically, cognitively, and psychosocially. During the teen years, adolescents experience changes in physical development at a speed unparalleled since infancy. This is often a time famed for growth spurts—rapid gains in both weight and height—and the development of secondary sex characteristics associated with puberty (Morgan & Huebner, 2008). Teens' brains also undergo significant development, affecting their ability to consistently

regulate their emotions, impulses, and judgment. Cognitively, teens are in the midst of developing more advanced reasoning skills, including the ability to think about multiple options and possibilities, and think about things hypothetically. The attainment of new mental abilities leads teenagers to believe that they are special and unique. Elkind (as cited in Rycek, Stuhr, McDermott, Benker & Schwartz, 1998, p. 745) refers to this phenomenon as adolescent egocentrism, in which adolescents assume that since they spend a considerable amount of time thinking about themselves, others must also be thinking about and monitoring them.

Perhaps the greatest of all developmental tasks of adolescence is establishing an identity. Teens begin to integrate the values and beliefs of influential others into their own likes and dislikes, moving toward an autonomous sense of self. It's often a time in which teens complain that their parental figures interfere in their independence, as they navigate the task of becoming less emotionally dependent on their parents. This normal behavior is often interpreted as rebelliousness, as teens try to establish some privacy and are sometimes more elusive about what they are doing and with whom. Under stress, however, adolescents often return to more childish behaviors. The teenager years often include frequently changing relationships, as adolescents practice social skills and learn how to begin, maintain, and terminate intimate relationships with friends. Adolescence is also the time of prime development of sexuality, when teens experience changing sexual interest and arousal patterns, and experiment with sex. (Morgan & Huebner, 2008; "Normal Adolescent Development," 2001; Prescott, 2001).

Over the last few decades there has been a growing body of literature focused on society's gender stereotypes of girls and the push to help girls feel empowered as they

enter womanhood. Pollack (1998) recognizes this trend in improving social conditions for girls, but also gives voice to the undertaking of the transition from boyhood to manhood. Men are encouraged to wear a mask of masculinity to hide their inner feelings and portray a tough image characterized by stoicism and strength, a concept Pollack (1998) named “the Boy Code” (p. 13). In order to live up to the stereotypes of men and masculinity, boys are often made to feel ashamed of vulnerability, powerlessness, fear, and need. They are free to express half of their emotional lives, Pollack (1998) says, displaying their “tough, action-oriented side, their physical prowess, as well as their anger and rage. What the Boy Code dictates is that they should suppress all other emotions and cover up the more gentle, caring, vulnerable sides of themselves” (p. 13).

It is the ideology of traditional masculinity, Kimmel (2000) claims, that encourages boys to take on the inauthentic voices of bravado, foolish risk-taking, and gratuitous violence. “From an early age,” Kimmel (1999) says, “boys learn that violence is not only an acceptable form of conflict resolution, but one that is admired” (p. 80). The widespread assumption that “boys will be boys” maintains the expectation that boys simply are overly sexual, aggressive, hardened, and emotionally withdrawn (Kimmel, 2000; Pollack, 1998). Therapists Kindlon and Thompson (1999) claim that our culture imposes a destructive emotional training on boys, threatening ridicule or emasculation of boys who demonstrate vulnerability or sensitivity.

Sexuality and Adolescents in Residential Treatment

Many of the “normal” tasks of adolescence come under scrutiny in the residential setting. At a time when most adolescents are separating from their parents while simultaneously developing into more autonomous and freedom-seeking individuals,

youth in residential care are constantly under close supervision (Schneider, Berman & Aronson, 1984). Troubled adolescents in residential care are not different from other teenagers in, for example, their developing sexual feelings, thoughts, and identities. Many, however, are in residential care because of poor judgment, little self-control, and destructive attitudes, and are therefore monitored much more closely than teens not in residential care (Pazaratz, 2003; Powers, 1993). Sexual problems among troubled adolescents in residential facilities are common, and many residential programs provide services for youth with histories of sexual behavior problems (Powers, 1993; Prescott, 2001).

According to Ponce (1993), youngsters in residential treatment are usually highly disturbed, coming from dysfunctional family and support systems. Many children in residential treatment have histories of physical, emotional, and/or sexual abuse, putting them at increased risk of abusive acting-out (Lyman & Campbell, 1996). Sex and sexuality are “their core developmental and psychopathological issues” (Ponce, 1993, p. 115). Sexual identity and sexual development become major concerns in therapeutic communities for adolescents, and are central to the management of disturbed adolescents in residential care. This presents an inherent contradiction in the treatment of adolescents in residential settings (Schneider & Deutsch, 1985). While treatment facilities encourage adolescents’ age-appropriate emotional development and identity formation, sexual activity in the residential setting is highly discouraged, and the youth do not have the complete freedom to explore interpersonal relationships (Schneider, Berman & Aronson, 1994; Schneider & Deutsch, 1985). For a number of reasons, the presence of sexually charged behaviors creates conflict and dilemmas for the staff in residential facilities.

Lyman and Campbell (1996) argue that “staff should be trained to neither deny nor normalize pathological acting-out, nor take repressive measures against developmentally normal sexual behaviors” (p. 67).

There is a limited amount of current research published on the management of sexuality in residential settings with adolescents. Prescott (2001) believes that valuable treatment, especially for sexually abusive youth, must focus on “the promotion of social competency, a healthy sense of masculinity, values clarification, and improved awareness of one’s actions on others” (p. 46). More specifically, Caldwell and Rejino (1993) state that program philosophies should directly address sexuality as a developmental process. Realmuto and Erikson (1986) note that some facilities do not acknowledge sexuality as a significant milieu issue necessitating particular attention. This is often due to staff members’ own values related to sexuality and personal discomfort with sexually charged issues. According to Schneider and Deutsch (1985), the clinical set-up of a therapeutic community must take into account the reactions of staff members who might struggle with identity issues or the developmental task of integrating lust and intimacy. Staff discomfort with sexual behavior issues is likely to inhibit the progress of the youth they serve (Prescott, 2001).

Most importantly, some would agree (Ponce, 1993; Realmuto & Erickson, 1986; Schneider & Deutsch, 1985), is the acknowledgment of the real and unavoidable countertransference—the partly unconscious, or conscious, emotional reactions to the patient— evoked through work with adolescents. Krimendahl (1994) notes that young patients can evoke particularly strong countertransference reactions in adults, but despite the proliferation of literature on countertransference and adult patients, there are very few

books published on its role in the treatment of children. Countertransference “difficulties with sexual issues reaches its apex with adolescent patients,” according to Schneider & Deutsch (1985, p. 372). The adolescents’ sexual identity formation activates sexual instincts and urges in an adult body. Ponce (1993) states that “erotic countertransference reactions are naturally occurring responses to youngsters’ developmental and psychopathological issues” (p. 118), and must be acknowledged, normalized, and processed by staff so that they may contribute to the therapeutic environment. It is also necessary for staff to understand that some attitudes or behaviors among staff and agencies may make sexual problems more pronounced among youth in residence. For example, Powers (1993) cites seductive behavior towards adolescents, seductive behavior among staff members in the presence of residents, sexual activity in the vicinity of the children, the wearing of inappropriate clothing by a staff member, and staff members discussing their past sexual prowess as such behaviors.

It is essential for the child care workers and the clinicians to maintain an awareness of both the influences they have over the youth in their care, and the influence the youth have over them. Analysts and therapists undergo long periods of schooling, where extensive training and self-examination are required. However, residential staff generally do not have such requirements, making them more susceptible to the push of children’s projections (Ekstein, Wallerstein, & Mandelbaum, 1959; Ponce, 1993). Additionally, direct care staff often encounter dilemmas because of the informal settings and personal investment required by this work environment, compared to other “professional” workplaces. Clinicians’ relationships with the children are set up in a manner that outlines expectations of the therapeutic alliance, and allows for transference

issues to be dealt with safely and professionally. Although direct care staff more regularly engage the residents in normal adolescent activities and routines, which require shifts in boundaries, they typically do not receive the same support and supervision as clinical staff.

Moses (2000b) reports that, while child care workers have largely been overlooked in research on residential treatment, there is a direct relationship between staff behavior and attitudes and youth's behavior and progress. One of the most powerful ingredients of the milieu, Redl (1959) argues, is the attitudes and feelings of the staff that fill the environment. He explains that the all-over group atmosphere, including leadership tensions and group processes, is a powerful force to which the adolescents are exposed. Unprofessional conduct between staff and residents, or between two or more staff, or failure to adequately perform required tasks can damage the integrity of an entire program if not responded to in adequate, relevant ways. Shiendling (1999) states, "Ultimately the effects of poor performance trickle down to the clients, and diminish, delay, or halt their progress" (p. 21). Another common problem in residential treatment is the imbalance of power between the residential, clinical, and educational components of the program, where clinicians are sometimes viewed as more powerful than the line staff (Prescott, 2001). Although they are nearly impossible to measure, the invisible dynamics and the culture of the facility become as influential as the adolescents' tangible surroundings. Similarly, while youngsters respond to what is said, they respond just as strongly to the unspoken "value systems that ooze out of our pores" (Redl, 1959, p. 727).

Gender in Residential Treatment

Many co-ed residential facilities segregate male and female adolescents into discrete units, and other facilities serve only males or females. While some studies have recognized psychological, behavioral, and diagnostic differences between male and female adolescents in residential care, there seems to be very little research addressing gender-specific service needs or responses to treatment programs (Connor et al., 2004; Riehman, Bluthenthal, Juvonen & Morral, 2003). According to Handwerk et al. (2006), “gender differences in residential care seem to be an area ripe for investigation” (p. 312), and “the lack of knowledge about and attention to gender-based issues in residential treatment is unjustifiable” (p. 321).

Researchers (Gilliland-Mallo, 1986; Pazaratz, 2003; Prescott, 2001; Stein, 1995) believe that effective residential treatment provides suitable role models of healthy behavior and effective, respectful communication, enveloping the residents in a positive, stable emotional atmosphere. However, despite the fact that none of these qualifications are gender specific, programs serving boys are often hesitant to hire female staff because of the concern that they may not be able to manage residents who act out or become aggressive or violent (Stein, 1995). Research on the gender of staff who are assaulted in psychiatric health care settings has been limited, with even less on residential treatment settings for adolescent males (Flannery et al., 2001). Having both male and female staff presents the opportunity to model healthy relationships, and it becomes a chance for the boys to learn pro-social behaviors in interacting with women. Working in residential treatment facilities, particularly with adolescent males, admittedly does not suit every

personality, and does require much physical and emotional resiliency, but these characteristics are certainly not inherently male or female.

Some aspects of residential treatment of adolescents have earned considerable attention from researchers, like the significance of family involvement (Nickerson et al., 2006) and the effects of residential treatment (Frensch & Cameron, 2002). Some researchers have also studied training needs for staff in residential treatment facilities (Fyhr, 2001; Leichtman, 2006; Lyman & Campbell, 1996; Pazaratz, 2003), and discussed the significance of their work in the rehabilitation of emotionally disturbed adolescent males. While Stein (1995) mentioned that administrators of residential facilities exclusively for the treatment of males are often hesitant to hire female staff, a thorough review of the literature uncovers virtually no research on the experiences of the women who work in residential treatment for adolescent males. Traditionally male workplaces, or workplaces in which stereotypically masculine attributes are revered, have reportedly been the settings where sex discrimination is likely to take place (Bond, Punnett, Pyle, Cazeka, & Cooperman, 2004; Coburn, 1997; Swim et. al, 1995). Residential treatment facilities for adolescent males are male-dominated because of the clientele served, but also because of the assumption that females may not be able to manage the youth's behaviors. In a setting that necessitates trust, comfort, and healthy communication between staff members to ensure optimal care for the residents, understanding the experiences of female staff members is critical to evaluating effectiveness of the residential milieu.

Sexism and Stereotypes

Sexism, broadly defined by Nelson (2002) as “negative attitudes and behavior towards someone on the basis of their gender” (p. 192), is the theoretical root of gender stereotypes and socially prescribed gender roles. Before the Second Wave of feminism, sexism was conceptualized much differently than it is today. It was characterized by open endorsement of traditional gender roles, differential treatment of women and men, and stereotypes of women as inferior to and less competent than men. Today, the idea of sexism has largely moved away from this old-fashioned sexism to what is being called modern sexism (Fiske & Lee, 2008; Nelson, 2002). Modern sexism is indicated by the denial of continued discrimination where it persists, hostility towards equality for women, and the lack of support for policies and legislation designed to help women (Nelson, 2002; Swim, Aikin, Hall, & Hunter, 1995). In the past several decades, while there may have been actual attitudinal changes associated with the increased entry of women in the workforce, it has also become socially unacceptable to admit to prejudices and to appear sexist (Burgess & Borgida, 1999). Because it is easier to focus on beliefs than on biased feelings, researchers have begun to focus on stereotypes rather than prejudice.

According to social psychologists and behavioral scientists (Fiske & Lee, 2008; Goldman, Gutek, Stein, & Lewis, 2006), stereotypes are beliefs and categorical associations about group members, including traits, behaviors, and roles, based on their group membership. Gender and racial or ethnic stereotypes are two of the most prevalent types because of generally visible differences, and thus, the speed of categorizing people on these dimensions. While stereotypes serve some cognitive purposes—to organize and

structure the abundance of information people in everyday life are confronted with—they are also frequently accompanied by inaccuracies and gross generalizations (Burgess & Borgida, 1999; Fiske & Lee, 2008). While one can hold stereotypes without necessarily engaging in discriminatory behavior, the two often go together (Goldman et al., 2006).

Burgess and Borgida (1999) acknowledge the dual nature of gender stereotypes. While there is substantial overlap, they note that the descriptive component of gender stereotypes specify characteristics women do possess, and the prescriptive component consists of beliefs about the characteristics women should possess. Both may have disparate effects on women's experiences in the workplace. Women are allocated to jobs according to socially pervasive stereotypes; men and women are thought to differ in terms of achievement traits, labeled "agentic," and social traits, labeled as "communal" (Burgess & Borgida, 1999; Fiske & Lee, 2008; Heilman, 2001). Because women are thought to have more communal characteristics, like compassion, care, emotionality and nurturing (as opposed to agentic qualities, like assertiveness, independence, and decisiveness), they are therefore thought to be especially qualified for positions that rely largely on those characteristics (Heilman, 2001; Nelson, 2002). Descriptive stereotypes portray women as unsuitable for certain jobs that require stereotypically masculine traits and attributes.

According to Cohn (1996), the process by which jobs are designated as male or female is called occupational sex-typing. Subjectively positive stereotypes of women, such as compassionate, emotional, and flexible, reinforce subordination and portray women in ways that are frequently detrimental to their role as workers (Burgess & Borgida, 1999; Fiske & Lee, 2008). Male-dominated workplaces often encourage and

value toughness, and discourage or scorn other emotions (Elmore, 2007). Although occupational sex-typing has received the most scrutiny, sex segregation is also prevalent within a job or organization. Women may be excluded from certain roles, and are assigned to other, often lesser-status, work activities, responsibilities, and undertakings according to corresponding gender stereotypes (Elmore, 2007; Jacobs, 1996).

In the Numerical Minority

Goldman et al. (2006) argue that the type of people who are common in any particular job are viewed as the most appropriate people to hold the job. The idea of women's gender roles taking precedence over their work roles is captured in a concept called "sex role spillover," according to Welsh (1999), and occurs more frequently when the gender ratio in a workplace is heavily skewed toward either men or women. Skewed situations, in either direction, make "femaleness" more visible and salient. Being in the numerical minority comes with certain consequences: "because the token is unusual in that position, attention is likely to be focused on whether or not the token can perform as well as the people who have traditionally held that job" (Goldman et al., 2006, p. 797). Additionally, differences become highlighted, often leading to increased solidarity among the majority group members. Women who are in the minority may also be expected to enact one of four stereotypical roles: mother, pet, sex object, or woman who rejects those roles.

Penalties for Crossing Boundaries

As a hegemonic society where women largely remain in subordinate positions, women competing with men for jobs in male-dominated workplaces are likely to face male coworkers emphasizing their status as women over their status as workers (Welsh,

1999). All individuals have multiple and overlapping identities, and “any given dimension of a person’s identity may be more salient or prioritized in one setting and less salient or prioritized in another” (Greene, 2007, p. 51). Calling attention to gender allows men to keep women subordinate. In certain workplaces, this may be manifested in concerns about women’s ability to perform certain tasks that are thought to fall outside of their stereotypically prescribed capabilities. It also may surface in males presuming that the females need to be saved or protected. In workplaces that are male-dominated or require stereotypically masculine traits, female employees’ performances are viewed through gender stereotypes, and are disadvantaged by their perceived lack of fit (Cohn, 1996; Nelson, 2002). Since perceivers expect less competence, female employees are often held to biased performance standards and are required to perform at a higher level to demonstrate competence (Fiske & Lee, 2008; Heilman et al., 2004).

Additionally, women in positions of authority are often perceived as most acutely violating societal expectations when they display assertive, tough, achievement-oriented behaviors for which men are so positively valued (Burgess & Borgida, 1999; Heilman et al., 2004). Some women even become tougher or take on stereotypically male traits in management positions to try to assimilate or succeed (Elmore, 2007). Particularly in male-dominated fields, even when female managers’ work-related strengths and competency are acknowledged, their interpersonal abilities and personality are often harshly criticized (Burgess & Borgida, 1999; Fiske & Lee, 2008). According to Heilman et al. (2004), success can be costly for women, as competent women, compared with competent men, have been depicted as cold and undesirable as fellow group members. In order to succeed and be liked, women must maintain a delicate balance. Fiske et al. state:

Because many behaviors considered inappropriate for women are the very ones deemed necessary to be ‘competent’ in the traditional male job, sex stereotypes create a double bind for women. Their competence is undervalued if they behave in traditionally feminine ways, while their interpersonal skills are derogated and their mental health is questioned if they behave in traditionally masculine ways. (as cited in Burgess & Borgida, 1999, p. 687)

Calling attention to gender may sometimes generate even more hostility, as individuals may be punished if they don’t behave as they are expected to behave (Goldman et al., 2006). Women in non-traditional or male-dominated occupations report feelings of isolation and resentment from male co-workers. They are perceived as violating stereotypes, and are often the recipients of hostile, degrading actions from men who resent the intrusion of women into their domain and seek to enforce gender stereotypes (Burgess & Borgida, 1999; Dunn, 1996). Heilman et al. (2004) also argue that negative feelings about successful women may have consequences beyond social rejection, as “being disliked was shown to strongly affect competent individuals’ overall evaluations and recommended organizational rewards, including salary and special job opportunities” (p. 426).

Sexual Harassment

In the workplace, women experience sexism through direct harassment, ranging from practical jokes, sexual advances, and workplace sabotage (Dunn, 1996), or more indirectly, through demeaning comments about women, or the exclusion of women from work teams or informal work networks (Bond, Punnett, Pyle, Cazeka, & Cooperman, 2004). One of the more persistent forms of sex discrimination, but one of the few punishable by law, is sexual harassment, a common problem in the workplace. The

United States Equal Employment Opportunity Commission (2008) defines sexual harassment as:

unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when this conduct explicitly or implicitly affects an individual's employment, unreasonably interferes with an individual's work performance, or creates an intimidating, hostile, or offensive work environment. (para. 2)

According to Coburn (1997), sexual harassment occurs more frequently when women enter traditionally male fields, but occurs in every occupation. Feminists have defined sexual harassment as an abuse of power, as a means of keeping women in a position of subordination by creating a hostile environment (Coburn, 1997; Marshall, 2005). In essence, "sexual harassment is often about letting women know they are not welcome in certain workplaces and that they are not respected members of the work group" (Welsh, 1999).

Sexual harassment may be thought of as gender discrimination, as it is designed to enforce and regulate gender stereotypes (Burgess & Borgida, 1999). Gender harassment, defined as any sort of nonsexual, gender-based experiences, like derogatory comments or jokes about women (Buchanan & Fitzgerald, 2008; Welsh, 1999), falls under the category of sexual harassment. Unwanted sexual attention—sexual jokes, comments or gestures—and sexual coercion are also forms of sexual harassment that contribute to what researchers call a "hostile environment" (Buchanan & Fitzgerald, 2008; Neville, 1999; Welsh, 1999). A hostile environment is created by an employee who subjects others in the workplace to sexual remarks, sexual jokes, or any behavior of a sexual nature, which may be offensive or intimidating. As Neville (1999) warns, "The workplace is not our home. It belongs to everyone" (p. 99), and people cannot work

effectively if they feel that an unwanted sexual climate exists around them. Sexual harassment can negatively affect one's job satisfaction and commitment to one's organization, and is also associated with increased rates of depression and anxiety (Woods, Buchanan, & Settles, 2009).

Sexual harassment is extremely difficult to define and measure, for a number of reasons. The term covers a broad range of behaviors, and spans across personality types, and so "what constitutes sexual harassment may be subjective, based on an individual's perceptions or the organizational context in which she works" (Welsh, 1999). A 1998 CNN/TIME poll (as cited in Neville, 1999) reveals that there is a general consensus on some issues, but public opinions diverge as the boundaries between overt and implied sexual behavior become murkier. Sexual harassment researchers have found that individuals often report being the targets of unwanted sexual behaviors, but infrequently label this behavior as sexual harassment (Goldman, Gutek, Stein, & Lewis, 2006; Neville, 1999; Welsh, 1999).

Burgess and Borgida (1997) and Welsh (1999) propose that individuals with more traditional personal sex-role attitudes label fewer behaviors as sexual harassment. The culture or climate of a work environment may also help to explain workers' attitudes towards and perceptions of sexual harassment (McCabe & Hardman, 2005). In sexually charged workplaces, sexual harassment often becomes normalized. Blue-collar organizations with high levels of masculinity also seem to have more tolerant attitudes towards sexual harassment. Females employed in nontraditional occupations may be less likely to perceive behaviors as harassing, as the gender-role attributes associated with their occupation may cause them to present as role deviates. Some might consider gender

harassment the price women must pay for access into a male-dominated field. Other women don't report incidents as sexual harassment because of the fear of retaliation or the fear of their reputation being tarnished (Neville, 1999). Welsh (1999) states that "in some masculine work cultures, women, in order to be seen as competent and as team players, may not define their experiences as sexual harassment" (p.174). The prevalence of sexual harassment also seems to be higher in organizations in which there are large power differentials between organizational levels (McCabe & Hardman, 2005). Finally, heterosexual norms in workplaces make sexual interactions between coworkers of the same race and sexual orientation seem less problematic.

Employers act as role models for their employees. An organization that promotes equal opportunities for women and men reduces sexual harassment. Welsh (1999) also points out that "it is when sexual interaction crosses racial, sexual orientation, or organizational power lines that targets of the behavior are more likely to label their experiences as sexual harassment" (p. 174). Research on workplace harassment has typically focused on either racial or sexual harassment, and a few studies have addressed the harassment experiences of women of color. According to Buchanan and Fitzgerald (2008), racial harassment refers to:

race-based differential treatment that may create a pervasive hostile environment for targets, commonly in the form of verbal race-based harassment (e.g., racial slurs, ethnic jokes, and derogatory race-based comments) and exclusion because of race (e.g., being excluded from work-related activities and social interactions). (p. 138)

Berdahl and Moore (2006) state that women and minorities are often treated hostilely in traditionally male- and White-dominated arenas. The concept of double jeopardy proposes that the co-occurrence of racism and sexism places women of color at

increased risk for multiple forms of harassment. Also referred to as “a double whammy of oppression,” the idea is that “minority women are the primary targets of harassment and discrimination because they face both ethnic and sexual prejudice” (Berdahl & Moore, 2006, p. 427). While sexual harassment has been studied extensively, few researchers have simultaneously considered the role race plays in these contexts and experiences. Studies of sexual harassment have generally focused on the negative consequences for women without considering race, and studies of racial harassment have largely ignored how gender might influence these experiences (Berdahl & Moore, 2006; Buchanan & Fitzgerald, 2008; King, 2005; Woods, Buchanan, & Settles, 2009).

Summary

Certain aspects of residential treatment for adolescents have garnered significant attention from researchers for decades. It is widely supported that, in residential treatment, the milieu may be the most influential part of providing a corrective emotional experience for the residents. Effective residential treatment provides suitable role models of healthy behavior and effective, respectful communication, enveloping the residents in a positive, stable emotional atmosphere (Gilliland-Mallo, 1986; Pazaratz, 2003; Prescott, 2001; Stein, 1995). Additionally, because of the nature of their developmental stage, the residential treatment for adolescent males is a highly sexualized setting. Gender roles and sex discrimination in the workplace have also been topics of great interest to researchers and to the feminist movement. Male-dominated workplaces, and workplaces where traditionally masculine attributes are revered are typically the sites where sex discrimination and harassment are more likely to take place. Women are often expected

to perform traditional gender roles (Welsh, 1999), and those who appear to be violating gender stereotypes sometimes face harsh repercussions.

The lack of research on the residential treatment environment as both a therapeutic milieu and a workplace is striking. The research ignores a specific group of women and their workplace experiences. Residential treatment facilities aim to provide safe, emotionally corrective experiences and teach healthy, socially acceptable behaviors and attitudes (Bettelheim, 1949; Moses, 2000a; Moses, 2000b; Pazaratz, 2003). Because staff's behaviors and attitudes in residential treatment facilities are such significant predictors of the adolescents' rehabilitation, recognizing women's experiences as staff members may be significant in comprehending how effective residential treatment facilities are in meeting these goals.

To better understand the existing gender dynamics in the residential treatment of adolescent males, this study will give voice to the women doing this work and provide a different perspective on residential treatment facilities that treat adolescent boys. The study will be guided by the following research questions: How do gender stereotypes affect women's experiences working in residential treatment with adolescent males? How do women feel that they are perceived by co-workers and residents?

CHAPTER III

METHODOLOGY

As noted in the Literature Review, women's experiences working in residential treatment facilities for adolescent males seem to have been ignored thus far in the research. This study seeks to explore how gender stereotypes affect women's experiences, and how women feel they are perceived by their co-workers and the residents with whom they work.

Research Design

Since a thorough review of the literature did not yield any research dealing specifically with this topic, an exploratory study using qualitative methods was conducted. According to Alexander and Solomon (2006), a qualitative approach allows participants to use "their own words to describe and interpret their social worlds and experiences" (p. 253), particularly when these are less known to most researchers. An exploratory study seemed to be the most appropriate for this unstudied subject, as the purpose of the project was to obtain a beginning understanding of the experiences of women working in residential treatment facilities for adolescent males (Rubin & Babbie, 2007).

The nonprobability sampling technique of snowball sampling was implemented, which is used primarily in exploratory studies, and relies on a few members of the target population to provide the information needed to locate other members of that population. The data collection instrument was a structured interview made up of open-ended

questions, and interviews were conducted on the phone. A structured measurement instrument was chosen to ensure that all respondents were asked the same questions in the same sequence. Questions were written out in advance exactly the way they were asked in the interview. The wording and sequencing of the questions were carefully planned in an attempt to both maximize the comparability of the responses, and to reduce interview biases or inconsistencies (Rubin & Babbie, 2007). However, it is difficult to ascertain the validity or reliability of the measurement employed, as this instrument was created and used for the first time in this study. The data obtained through these interviews were carefully analyzed for themes.

Sample

The study sought to include women over the age of 18 fluent in English, of any race, ethnic group, sexual orientation, or any other demographic category. To be included in this research study, the women were required to be employed full-time in a residential treatment facility, or must have worked full-time in a residential treatment facility within the last two years. While initially only clinicians and direct care staff were invited to participate, the qualifications broadened to include a few case managers and a teacher after they expressed interest in participating. A residential treatment facility was qualified as a place that offers 24-hour a day care, and also offers clinical or therapeutic treatment to its residents. The treatment facility had to serve a population that included adolescent males between the ages of 11 and 18. Research participants must have worked full-time with only male residents. Women who worked in facilities that served both males and females must have been assigned to male units. At the time of the

interview, the women must have worked in the residential milieu for a minimum of nine months.

Ultimately, thirteen women participated in this research project. They ranged in age from 23 to 63 years. Nine participants identified as Caucasian or white, one identified as Latino, one as biracial, one as African American, and one as Haitian. The women ranged in length of experience at their current or last residential facility from one year to 22 years. Six women performed clinical roles, three were direct care staff, three were case managers, and one was a teacher. Ten women worked in residential facilities in Massachusetts, and three in New Jersey.

Procedures

In order to recruit participants, this researcher sent an e-mail flier to a number of people who know women who work in residential treatment facilities with adolescent males (See Appendix A). These individuals were asked to forward the e-mail to women who might fit the criteria and would be willing to participate. Since this research relied on a snowball sample, participants were not recruited for diversity of professional training or any other sort. As indicated on the flier, the possible participants were instructed to call or e-mail me to let me know that they were interested. Twelve participants responded via e-mail, and one responded on the telephone. Each woman was screened to ensure that inclusion criteria were met. See Appendix B for Screening Questions. Then, participants were mailed or faxed an Informed Consent form (See Appendix C). Each participant read, signed, and returned the signed Informed Consent form, and was instructed to keep one copy for her own records. Upon receipt of the completed forms, the participants were contacted to schedule a phone interview at a convenient time.

Ensuring the participants' confidentiality and privacy were of utmost importance in this project. Participants were all given a consent form approved by the Human Subjects Review Board (HSR) of Smith College School for Social Work. The HSR approval letter is also available in Appendix D. Additionally, as precautions to protect the participants' identities, their names were not connected to the interview materials. Designated interview numbers were used in place of the names immediately following the receipt of the Informed Consent. Informed Consent forms were also kept separate from the research instruments and the recorded interviews. The researcher transcribed the interviews, which minimized the risk of anyone else having access to the data. All material was prepared so that participants were not individually identifiable. As required by federal regulations, all audiotapes, notes, and transcriptions from the interviews will be kept in a secure location for three years. Should the materials be needed for further research beyond three years, they will continue to be kept in a secure location and will be destroyed when they are no longer needed. This procedural information was shared with the participants in the Informed Consent.

All interviews were conducted over the phone to facilitate long-distance interviewing and to maintain consistency across interviews. Secondly, the dynamics of the phone interview may have allowed for women to feel more comfortable disclosing sensitive information. Immediately before beginning the interview, participants were reminded that their interviews would be taped. As mentioned above, the standardized open-ended interview followed an interview guide (See Appendix E), which consisted of pre-written questions that were asked of each participant in the same order and using the same wording. Participants were oriented to the structure of the interview before it

began. The interviews began with several brief demographic questions, and participants were then asked a number of questions about their gender in relation to their specific job requirements. The next group of questions focused on participants' perceptions of their relationships with their co-workers, and with the adolescents in the facility. Finally, the participants were asked to reflect on their gender and racial identities, and how these affected their experiences. The interviews lasted between 20 and 45 minutes.

Data Analysis

Each interview was recorded and transcribed. Data collected in the demographic section was analyzed manually, and narrative data was analyzed by content and theme. All responses were separated and grouped into tables, question by question. Each question was analyzed for content and themes that emerged when examining the testimonies. The participants' job positions were noted next to their responses, so that similarities and differences might be more easily noted. Summaries of the themes are included in the Findings chapter.

CHAPTER IV

FINDINGS

This qualitative exploratory study was conducted to uncover and understand how women experience their work in residential treatment facilities that serve adolescent males. The interview questions were designed to inform the research questions: How do gender stereotypes affect women's experiences, and how do women feel they are perceived by their co-workers and the residents with whom they work? The interview focused on four different aspects of women's experiences: agency/job requirements or responsibilities, relationship dynamics with co-workers, relationship dynamics with residents, and their own perception of their gender and racial identities. This chapter presents themes that emerged through phone interviews with 13 women, all of whom work in all-male facilities, or units that only serve male youth.

The Participants

In order to obtain a diverse sample and a range of experiences, the original plan to only interview clinicians and direct care staff was modified to include case management staff and a teacher. Six participants reported performing clinical duties at their facilities, ranging from clinicians to clinical directors. Three participants were case managers, and one case manager reported having been a direct care staff member in the past. Three participants were direct care staff, and one was a teacher. Ten of the women worked in facilities in Massachusetts, and three in New Jersey. The women ranged in age from 23 to 63 years old, with a median age of 29 years, and a mean age of 35.2 years. Nine

participants identified racially as Caucasian or white, one identified as Latino, one as biracial, one as African American, and one as Haitian. The women's length of employment at their agencies ranged from 1 year to 22 years. The mean was 5.2 years, and the median number of years was 3.

The participants were asked to describe the tasks or duties they were responsible for completing. Responses to this question reflected the participants' job titles. Participants in clinical positions reported providing therapy to children, families, and groups, providing clinical supervision, coordinating treatment efforts with staff and teachers, training staff, and writing clinical evaluations and other paperwork. Participants who worked as case managers described their role as acting as a liaison between the agency and outside parties, including parents, probation officers, attorneys, and social workers, as well as writing individual service plans for residents. The participant who worked as a teacher stated that she must create lesson plans and provide education to the residents, ensure that Individual Education Plans are followed, and coordinate with the behavioral staff in the classroom. Direct care staff reported that their duties were to plan and carry out daily programming within their unit, maintain the cleanliness and safety of residents and the unit, provide age-appropriate bulletin boards, posters, and chore lists, teach life skills, supervise and counsel the residents, and, as Interviewee 10 stated, "what everyone else doesn't do."

Gender and the Job

Work Opportunities

The participants were asked whether they thought their duties at work had anything to do with their gender. Six (46%) reported that they did not. Three

participants (23%) stated that although their job descriptions are not specific to their gender, they felt that the way they are perceived and evaluated does have to do with their gender. As Participant 5, a clinician, said, “I don’t think the job description is specific to my gender, but I think the way my job has evolved, it probably does [have to do with my gender].” Participant 3, a clinician/clinical director, explained,

It’s not that black and white. I feel like the males tend to be able to get away with doing less, but I think the expectations are the same. In my experience, they just seem to get away with not meeting those expectations.

Four participants (31%) believed that the duties they are responsible for at work do have to do with their gender. Participant 4, a case manager, had a hard time articulating why she felt this way, but noted there are no male case managers at her agency. Participant 12, a direct care staff, noted,

You can just tell it’s because of gender, because not just in the cottage that I work in, but the other cottages too. It’s all the females that are doing that type of work. Like hygiene shopping, making sure the inventory of clothing is correct for the kids. You don’t really see the males going in there and counting the kids’ boxers or the kids’ socks, or how many sneakers they have, if they have a jacket or not.

When asked if they believed that their gender affected their opportunities at work in any way, five participants (38.5%) simply said they did not, without offering any further explanations. Three others (23%) said being a woman didn’t affect their opportunities at work, explaining their reasoning: Participant 1 explained, “It’s pretty widely accepted to be a female as a clinical staff,” and Participant 9 said that, having worked in this field for 23 years, she felt that her gender has become less important in how she’s perceived and how she perceives her opportunities. She said,

I think what I do, how I do it, how I’m viewed has very little to do with being a woman as opposed to the amount of experience that I have. . . . I remember being

told 20 years ago, “This is the old boys network.” And it’s not like that. I mean, there’s still some of that, but it’s not like that.

Five participants (38.5%) mentioned that gender stereotypical expectations did affect their experiences. Participant 5 felt that being a woman may have given her more opportunities at work over the years among a male-dominated management, but stated, “I think it’s helped that I’ve been perceived as fairly emotionally stable, and as a consistent and dependable person.” Participant 12 mentioned that while there are a number of female supervisors and assistant supervisors at her agency, “I think we might have to put in a little more than males do.” Two participants, both direct care staff, mentioned that male staff are generally chosen over female staff to manage situations with residents that call for physical strength.

Agency Trainings

Participants were asked what types of trainings specifically having to do with gender were provided by their agencies. Two participants (15.4%) reported that their agencies did not provide any such trainings. Two reported (15.4%) some sort of “diversity” training, three (23%) reported trainings that included policy review, six (46%) described self-defense or safety training, and three (23%) referred to trainings having to do with work gender roles or boundaries. The women’s reactions to these trainings were varied. Two participants, both case managers, felt that there was some merit to the trainings, and they were educational and beneficial. This specifically referred to keeping oneself safe. Three participants pointed out that the trainings were not useful or helpful in practical ways. Participant 1 said, “I didn’t feel that the training really gave anyone any insight into how to deal with the different clashes that can happen when you have all

of those different groups together.” Participant 3 echoed this statement: “I didn’t think it was really helpful to really address issues that come up.”

Three participants explained that the trainings were not equally required of male and female staff, and wondered why males were not required to participate. One such reaction was in response to male staff not being involved in a self-defense/rape prevention training. The two others were in reference to trainings that discussed gender dynamics among staff. Participant 12 explained that, in the training,

[We were] talking about how women get stuck with some of the more feminine things to do in the cottage, or in the facility. It was just all the women, though, in the training. I found it interesting that the males didn’t have to go through something like this but we did.

Similarly, Participant 13 described her opinion of the training:

I thought it was a good idea. However, I thought it was implemented poorly. They called it a “Women’s Issues Training.” And I spoke to somebody, just letting them know, like, “I don’t have any issues. I don’t need to go to training for it. Maybe you could change it to a gender issues training.” Not the fact that women have issues and we need to go and deal with them in a training, but a forum to discuss things going on. And they did not provide the same training to the males. It was only something women were required to go to.

Dress Requirements

When asked if they were expected to wear or not wear anything in particular to work, six participants (46%) used the word “revealing” to describe what type of clothing was not permitted for women. Another three (23%) talked about covering themselves. All 13 spoke of a similar expectation of dressing conservatively and not wearing anything “too short” or “too tight.” While a few referenced dress code policies, six participants (46%) spoke about the “nature of the place,” referencing to an already sexualized

environment. Because of this, they explained that women should follow these expectations. Participant 9 asserted,

I think given the nature of what this place is, and the population that we have, there is a certain way that you should dress. . . . I think it's common sense. You need to remember where you are. . . . There's already a level of sexual kind of tension here in the program because of all the issues that we talk about. I mean, we have lots of kids who have offended sexually, but we have a lot of kids who were sexually abused. And when you add that layer of sexual energy, it can be very disregulating for the kids.

Participant 1 shared, "One of the interesting things about being on an all male unit, especially a unit that houses a lot of sex offenders, is that women do have to kind of be aware of what they are wearing." Participant 8 agreed, saying,

In my mind, yeah it's a policy, but I think it's kind of the common sense thing. If you're working with kids that have sexual issues, it's kind of anti-your job to wear things that entice them, or that would, you know, maybe not purposely, but get them riled up, I guess.

While most of the participants connected these environmental dynamics to the male residents, two participants shared personal stories in which they felt "watched" or monitored by male staff members. Participant 2, an assistant clinical director, explained,

I think when a new female comes in to the fold, everybody—especially the line staff—are kind of protective, and they were watching me and I felt that they watched other women who started working there. Like, as a new employee, I felt very much watched by the other male staff, especially the older line staff, meaning the guys who had been there a really long time. Just to be on the lookout for any inappropriate clothing regarding anything that would stimulate the boys. . . . One time I was asked if I had on underwear, meaning a bra, I think because I had not a padded bra on and it was cold and my nipples were pointing out or whatever. And I was shocked that someone had brought that to the attention of my boss and he had asked me that question. He was very embarrassed about it. I was like, "Of course! Of course I'm wearing a bra!" I really felt after that that I needed to go buy some really padded bras and make sure that didn't happen. It was like the culture there. It wasn't necessarily for the kids. I didn't see it as for the kids. I wasn't worried about the kids so much. I was more worried about what everybody would think. That was weird.

Participant 12, a direct care staff, described an ongoing dilemma she experiences at work, in which different male supervisors recommend that she change her appearance. They alternate between advising her to wear clothes that look “more professional” and clothes that are looser-fitting. She said,

So this is like a big conflict that I go through, I wouldn't say daily, but maybe on a bi-weekly basis, that I have to go through somebody saying something about my clothing, and then me going back and being like, “Listen, my supervisor told me not to wear sweats anymore, so what am I supposed to do?” There's no middle there. . . . It's like a toss-up right now with the clothes. 'Cause you never know what's going to be okay and what's not going to be okay!

Both experiences seemed to cause the participants emotional discomfort and insecurity.

When the participants were asked how the expectation for women compared to what male staff are expected or asked to wear, five participants (38.5%) reported that the expectation is the same, and that men are also expected to dress in a modest fashion.

Participant 13 explained,

I think for the environment in which we work, you're doing yourself a favor when you kind of make yourself more gender-neutral. And that goes for the males, too. They don't need to be wearing clothes that are tight-fitting, like showing off their bodies, the same way that a female shouldn't be showing off her body.

Two participants stated that if male staff's appearances are criticized, it is for level of professionalism, and not for sexual inappropriateness. Seven participants (54%) pointed out that male staff's physical presentation is not monitored in the same way as female staff's, and they seem to feel freer in their clothing choices. Participant 2 said, “The men—I know for a fact that nobody was looking at what they were wearing.” Participant 3 reported a similar observation: “The expectation on paper was the same, but it wasn't followed through with as much with the males.” Participant 12 emphatically stated, “Male staff wear whatever the hell they want.” Five participants (38.5%) noted that there

is a heteronormative expectation, which leads to male staff ignoring the idea that their appearance may be arousing for some students. Participant 9 explained, “[I] have tried to educate the male staff—you know, don’t think these kids aren’t thinking about you, because they are.” Similarly, Participant 8 said, “There’s plenty of gay students that we have who might be equally as enticed by a male staff wearing something.”

Relationship Dynamics with Co-Workers

Gendered Expectations from Male Co-Workers

The participants spoke about the expectations they felt male staff had of them. Six participants (46%) included the words “nurturing” or “mothering” to explain the role they were expected to take in working with the residents. This seemed to mean stereotypically feminine roles, like processing issues with residents, helping soothe emotional difficulties, and doing “household things.” While she didn’t use these words, Participant 1 similarly explained that male staff seem to expect female staff to manage residents’ more vulnerable emotional reactions. She said,

The male staff have expectations that if anyone is having an emotional breakdown, if anyone’s feeling really upset about something, that I’m going to jump in and kind of take care of it, or soothe it and make it stop.”

Participant 5 stated, “I’ve seen them turn to me, for example, in situations where a boy might be emotionally upset and it’s something they’re not particularly comfortable dealing with.” Participant 6 described the expectation:

Male staff tend to lean on the females to be more nurturing. It does assume typical gender roles, in that the male is the dominant and the enforcer of the rules, and the females are kind there to lessen the blow when a rule hits a kid and they’re upset. Females are kind of sent in as the protectors or the ones that smooth over an issue. They’re definitely cast in a more motherly role.

The expectation of mothering and nurturing was juxtaposed with descriptions of male staff members feeling less comfortable when confronted with feelings other than anger or aggression. Participant 11 explained, “If it’s something that’s just not machismo enough for them, or just out of their element or they’re uncomfortable with, I think they look to me to—they expect me to deal with that.” Participant 1 said,

A lot of the staff here, they get uncomfortable with it when kids start crying. They’re more comfortable with it when the guys here get angry because they can understand the anger and they know how to deal with anger. You know, it’s either talk them down or restrain them.

While many of the participants in clinical and case management positions described the “mothering” role in this way, all three participants who were direct care staff described the “mother” role differently. Participant 10 referred to the expectation of doing “household things.” Participant 12 stated, “Making sure the kids are showered and cleaned every day, making sure their laundry is done. Making sure I’m playing the mother role basically is what they expect of us as women there.” Similarly, Participant 13 said, “Sometimes male staff expect females to just do more run-around type of work ... kind of like the grunt work.”

Male Staff’s Perceptions of Female Staff’s Competence

All participants were asked how they felt male staff perceived their competence as a fellow staff member. Seven participants (54%) reported feeling that their male co-workers viewed them as competent, and that they felt respected. Eight participants (61.5%) mentioned earning this respect, or being confronted with the task of disproving stereotypes in order to be viewed as competent. Participant 1 said, “I feel like they see me as pretty competent, but that’s also because I’ve set some pretty strong boundaries.”

She referred to a newer female staff at her agency who the male staff saw as a “flighty, naïve kind of girl,” and who subsequently had trouble asserting her authority. “The kids were taking her less seriously,” she continued. “They didn’t see her as a force to be contended with.” Participant 9 described her experience:

I think I’m perceived—well, I can be a pain in the ass, I know that, because I have very high expectations. But I know that they’re very comfortable coming and asking me to help out, and know that I can handle a room full of kids without any difficulty.

Participant 8 shared, “I’m not a complete pushover. Like, I’m sturdy. I’m not a small, wilting female. I can handle myself.”

Four participants (31%) indicated that there is a divide in perceived competence or expectations based on one’s role in the facility. Participant 5, a clinician, explained,

Generally, as far as what they expect of me clinically, they find me competent, I think. I don’t think they would see me as competent if I were, you know, to go toe-to-toe with them, trying to be a line staff, trying to deescalate a situation that was getting physical. I don’t think they would want me anywhere near that situation.

Participant 8, a teacher, noted, “There’s two parts to that. There’s the teacher part and then there’s the staff part.” While her teaching skills may not be questioned, her ability to manage high-impact situations may be. Participant 4, a case manager who worked first as a direct care staff, explained how her roles have affected how she was assessed by male staff:

Since that’s where I started, I have that perspective, too. So I think I’m respected for that. I do realize that they know the kids better, they’re with them 40 hours a week, and they have the harder jobs, definitely. I definitely don’t minimize what they do. And I think it might be easy to do that if you’ve never—you know, I think it’s easy to look at them as, like, glorified babysitters if you’ve never done it before. And if you have done it before, you know it’s a lot harder than that.

Expectations of Female Co-Workers

The participants spoke about the expectations they felt other female staff had of them. Five participants (38.5%) referred to an expectation of being an advocate or a support for other female staff in the male-dominated environment. Participant 2 explained,

I felt like I needed to be able to be kind of aware of issues surrounding gender discrimination and any kind of problem she might be having. . . . I certainly have felt in a couple of different situations that I expected myself to be an advocate for women.

Similarly, Participant 3 stated,

I think other female staff looked to me to sort of protect them and be supportive because I tended to be one of the more assertive females, and I wasn't afraid of conflict or confrontation in order to stand up for the kids and what I believe is right.

Three participants (23%), all of whom were clinicians or clinical directors, noted their years of experience and reported that they felt female staff looked to them for guidance in navigating the specific environment. Participant 5 said,

The new women staff who are hired look to me for some guidance and direction, and really some role modeling as to how to deal with an environment where we're a minority and we have to deal with a lot of testosterone floating around.

Participant 11 echoed, "In terms of just being in a male-dominated facility. . . . I think they look at me for guidance and how to sort of balance out dealing with the males at large."

Five participants (38.5%) stated that other female staff expected them to simply do their jobs while maintaining emotional toughness and firm boundaries. Participant 8 described this expectation: "There's a lot of like, 'Do your job and don't stir up the

waters' at my job. . . . Just do my job, don't be a pain in the ass, and don't cause distractions." Participant 1 offered,

I think that among the women here, which includes teachers, the expectation is that we are going to be firm on our boundaries and also be firm on following the rules and being consistent with the kids. . . . It's almost like we have to work harder as women to do that to overcome the image that we're just the wishy-washy, nurturing, soothing type of people whose emotions can be played upon to change things.

Participant 12 spoke to this:

The female staff there are a bunch of girls that are very independent and strong women. I mean, you have to be to work in this kind of field. Otherwise I can only imagine what you'd leave there every day as. But, I think that they just expect us to stick together, and go in and do what we gotta do.

Sexual Harassment Experiences

Participants were asked if they have ever experienced a male co-worker touching them in a way that made them feel uncomfortable, asking them about sexual relationships, or making sexual jokes or references. Six participants (46%) reported that they had not personally had any of these experiences. Six participants (46%) said they had experienced male staff making jokes or comments of a sexual nature, or that targeted women. Participant 3 remembered male co-workers talking about an attractive blond clinician with whom she worked. She stated, "There were a lot of things focused around her being a female and being blond, and just a lot of rumors about—conversations between staff and the kids about her giving good blowjobs, and just really disrespectful sexual things." Participant 1 shared, "People make a comment about, 'Women shouldn't have been able to vote,' and, 'Women are going to go in their office and cry if something goes badly.'" Similarly, Participant 3 reported that a male program director at her agency

told her that she “made too much money for a female.” Participant 10 described a few incidents with male co-workers:

I had a couple of male staff get my number off the public folder and call my personal cell phone and ask what I was doing off company hours. I had a couple male staff ask what I was doing, or what I like to do, being inappropriate a couple of times. There’s just a couple times in general.

Participant 12 was the only person who specifically disclosed being touched in ways that made her feel uncomfortable. She talked about a male co-worker who was a supervisor at her agency. She explained,

He would grab my arm, or grab me by my sides, or pull me out of a place where I was in, or make me, like, get away from going to talk to somebody. Or he would just have something to say about me. That’s just, like, one guy. Another guy I’ve had definitely a lot of talk about my lower bottom area that I hear. And I don’t know, it’s very inappropriate. . . . I mean they’re just pigs that work in this fucking facility.

While Participant 5 stated that she had not experienced this herself, she recounted a story in which a male co-worker stood in a doorway, blocking the path of her female supervisor. “He reached over and hugged her,” she said, “and it freaked her out because it was completely unprovoked.”

Four women mentioned that they felt torn about the objectives of the comments, or that they believed the comments were not intended to be offensive. Participant 11 talked about an older male co-worker who refers to her as “little girl”: “It drives me nuts, but then I realize it’s his term of endearment. But it still drives me crazy.” Participant 13 revealed that male co-workers asked her about her sex life, but asserted that it did not make her uncomfortable. She said,

There was never a malicious or sexual intent. I think mostly it was just curiosity. I guess the individuals that had expressed that curiosity, I had a working

relationship with them so it was appropriate for them to ask what they did, or say what they did.

Participant 8 said that it's difficult to avoid sexual jokes and references at work because "there's fodder everywhere you go." She explained,

There's always someone flashing somebody, or jerking off into a cup and trying to pass it to another kid, or something gross and disgusting, so it's kind of hard to get away from that. So the chatter is there. I don't know, after working there for five years, everyone sexually has this kind of annoying radar, where we take things all the wrong way because we're trained to do that. . . . I think once staff are talking about stuff, it kind of just opens the conversation.

Five women mentioned that, when faced with the above-mentioned comments or behaviors, they handled the situations themselves and confronted the male staff who had delivered them. Referring to derogatory comments made about women, Participant 1 said, "I never let them slide. I'm always like, 'Excuse me, what did you say?' I deal with it head on only because I've seen what can happen when you don't." Participant 3 described an incident in which a male staff told her he preferred when she wore her hair a certain way. She told him,

"Well, I don't feel comfortable with you making any comments about my appearance, and you're bordering on sexual harassment, so let this be the last time that you're making any comments about the way that I look." And it was the last time.

Two added that, even if they listened, the men reacted hostilely after being confronted. Participant 12 said,

I went up to the guy and I just asked him what his problem was, and why he was harassing me and targeting me and all that. He was like, mind-boggled that I would even have the balls to say something to him, and just tried to turn it around on to me in some twisted, manipulating way.

Participant 3 described what happened after she advised the male staff member that his comments about her appearance were not welcomed:

[He] sort of created, in some sense, a hostile environment because I wasn't too friendly with him, or friendly to the extent that he wanted me to be. So just creating some difficulty. Like, side comments. Nothing sexual, just in general to make it an uncomfortable environment. And when I spoke to another supervisor about it, saying, "I really need to get along with this person because we're working together," he said, "Well, he doesn't like you because he knows he can't get in your pants." So, there's nothing to get out of that relationship, so why bother.

Two women, both direct care staff, mentioned that they brought the incidents to the attention of their superiors, but were somewhat unsatisfied with the way it was handled. Participant 12's direct supervisor told her to "Brush it off." She said,

I didn't say anything right away because, you know, you get intimidated, and you don't want people to frigg'in' know. And it's a small work environment, people talk, and I didn't feel like it was going to be confidential whatsoever, so I just kept it to myself.

They alluded to the fact that women sometimes come under closer scrutiny after reporting incidents. Participant 12 said,

Ever since then, I've been watched. I'm like told to be on my p's and q's. So I felt like they weren't taking his side, but . . . that they would rather get rid of me rather than have him gotten rid of.

Relationship Dynamics with the Residents

The participants were asked how they believed the residents acted towards them compared to how they acted towards male staff. Five participants (38.5%) believed that residents softened their actions and behaviors around female staff, and were less aggressive. Participant 5 said, "Oh, they're much easier on me." Participant 4 explained,

I definitely feel like if they're having an issue and being aggressive, even if it's just like punching the wall or something, I feel like if a female staff, or I'll say myself, but usually any female comes in and tried to talk with them, they'll be quicker to calm down and try to process the issue out.

Participant 1 also spoke about the difference:

When they do something wrong, they're fine with going off on a staff member, a male staff member, yelling at him, swearing at him and expressing their feelings in a really aggressive way. But when it comes to talking to me about it, I can sense that they soften it up a bit because they don't want to upset me or offend me and they don't want me to be disappointed in them.

Four participants (31%) mentioned that residents seemed to be more willing to be more vulnerable. Six participants (46%) believed that the residents' relationships with male and female staff were individualized, and didn't feel that there was a general way that residents acted towards female or male staff. These participants seemed to feel that this had to do with the residents' specific histories or needs, and the relationships they developed with specific staff members. Participant 7 said,

It's not something that you can say in a generalized way, because it's true that some kids are more disrespectful to women than to men as a personal issue that they might have . . . but it's part of the treatment. I mean, it's something we figure is part of their issue, and we work with them.

Participant 2 described her agency's commitment to treating the individual, and understanding each boy's history, level of functioning, and specific needs. She stated,

I think that thinking really trickles down from the clinical approach to the culture in general. You know, I feel like it was about the individual, not anything other than that. So I do believe the kids had individual relationships with each person.

Finally, four participants (31%) mentioned that they felt their clinical role strongly affected the way residents acted towards them. Participant 1 said, "It goes not just with me being a woman, but also me being the clinician. In a lot of ways it's like I'm mommy and they don't want to disappoint mommy." Participant 3, after stating that the residents were more receptive, less aggressive, and better able to express vulnerable feeling to female staff, added, "The clinicians tended to be females and the staff tended to be males, so there's also that dynamic where, with the clinical relationship, it is easier for kids to be able to do those things." Similarly, Participant 5 felt the kids were much easier

on her. She said, “I think my role, my clinical role, has a lot to do with that. They see me as someone who’s there advocating for them and helping them, and not really having to mete out consequences or discipline.”

The participants were asked to describe the difference between sexually charged comments made by male residents that were aimed female staff compared to those aimed at male staff. Five participants (38.5%) agreed that comments aimed at male staff were not personal, were expressions of anger or aggression, or were intended to test limits. “It’s more about anger and less about sex,” according to Participant 9. Participants explained that comments aimed at female staff, on the other hand, tended to be exploitive, focused on their bodies, and were often expressions of arousal. Participant 13 explained, “It has to do with making them feel a certain type of way, [whether] it’s uncomfortable about themselves or their bodies, or the residents suggest something sexual about the females.” Participant 3 addressed the distinction:

Comments made toward male staff that were sexual in nature weren’t meant personally at the staff. It wasn’t like, “I want to go to bed with you,” or, “I like you,” or, “I like this about your body.” It was more like, “F you.”

Five participants also noted that behaviors targeted at female staff differed in that it was often done in the form of talking or gossiping between residents. Sexual attention was sometimes conveyed in more subtle, less explicit ways. Participant 11 tried to put this into words, saying, “It’s done in a way that’s kind of not directive, but kind of like subtle in its nuances, if you don’t pick it up. And it’s a look, too. And I think with the guys, they wouldn’t do that.” Four participants also pointed out the heterosexual norm in the facility, and that gay residents were less likely to talk about male staff in a sexual way. Participant 6 shared, “I think it’s more prevalent with the students and the females

than it is the males because there are more straight students than there are gay or bisexual.” Participant 11 explained, “You know, most of the kids are heterosexual, but if there were kids who were homosexual, I don’t think they would come out, just because of what the repercussions might be, just because it’s such a machismo environment.”

Nine participants (69%) stated that when residents make sexual comments to staff, it’s treated as a clinical or therapeutic opportunity. As they explained, the occurrence of an incident like this corresponds well with the goals of residential treatment. Participant 4 stated,

We do a lot of processing and talking about why it’s not appropriate and why it’s not okay, and how it can make other people feel. I mean, that’s a big part of what kind of goes on here, just the nature of the kids that we treat.”

Participant 8 pointed out, “That’s kind of what we do: we re-program these kids. At least the goal of the program is to re-program them to be more pro-social.” Five participants also noted that consequences were generally given out in response to making sexual comments. Participant 2 spoke to both of these types of interventions, and said,

You wanted to figure out what was making them act out sexually in the first place. That’s why they’re there. So if they start acting out sexually in the program, it’s kind of a great opportunity to say, “What’s going on that causes this?” It was looked at both in terms of that they were punished, but also, it was dissected.

Three participants (23%) talked about responding in ways that purposely disempowered any such comments. This included promptly naming and addressing the behavior with the resident. Participant 6 explained,

If she works with that student on a daily basis, or every other day, we wouldn’t take her out of that position because that would give that student power. You know, he could see that he has that power over that female, or the supervisor, to remove somebody, so we don’t let that happen. We don’t give that power to the students.

Participant 13's opinion was similar: "The child needs to be addressed. The females should always be involved so that they seem empowered, and the child isn't inflicting that sense of control or dominance that they might be looking for."

Three participants (23%) noted that they sometimes witnessed or experienced male staff not taking such comments about women as seriously, or actually joining in with the residents. Participant 3 said that when comments were made about women, it seemed to be more expected and justified. She said,

Like, 'Oh well, she's a girl and they're going to have fantasies, and, "This is why girls shouldn't be working here.' And staff would actually engage — feed into those conversations, like, 'Oh yeah, that person had a nice behind or nice breasts.'

Participant 1 shared a similar perspective: "Other staff members who are hearing sexual comments are not taking it as seriously. They are laughing it off as a joke and they're not jumping to the defense of a woman who the joke is made about."

Identity Intersections

The participants were asked to reflect on what was unique about being a woman in this particular environment. While the participants' responses varied greatly, a common theme that emerged was that women noticed that their presence in the facility seemed to change the atmosphere, and acted as a stabilizing force. This centered around assumptions that male staff generally acted in certain ways. For example, Participant 1 said,

What's unique about it is you get to realize all of the different things that men do around you to tone themselves down. You get to see kind of like the before and after. You can see what it would be like if it were just all men, all the time, which is testosterone-charged, all about power and control, all about making lewd comments, not caring about personal hygiene, including belching and farting and talking explicitly about sexual things, versus when you add the woman into the mix. It really does seem to tame some of that. . . . It really does seem that without

that kind of woman influence to keep the male perspective in check, it would become a lot more violent and power-driven than it is when women are there. A stabilizing factor, I think.

Similarly, Participant 11 stated, “What’s unique is that sometimes just my presence, just being there, people are able to kind of shape up.” Participant 5 spoke about expectations residents often have when entering a residential facility. She said,

[The kids think they] are going to have to deal with these burly, short-tempered men, and, you know, being told where to go and what to do, and so forth, and I think it helps that there are some people placed in their path who are caring females and who are advocating for them and representing a different side of the experience.

Four participants felt that, as women in this environment, they are able to be versatile and flexible in their workplace roles. Participant 10 explained,

I can give them information in different areas. Like, I can talk to the kids about sexual orientation. I can talk to them about life skills. I can be with them when they’re struggling, I can be with them when there are good days. Sometimes it’s hard for male staff to be flexible in that.

Participant 11 spoke about her ability to use different aspects of herself as a woman in her work with co-workers and residents. She said,

I can be as feminine as I need to be, but I can also be the strong girl who’s aggressive, go-getter, and all that good stuff. And depending on what hat I wear, I think I can balance that out when it’s going to benefit me.

A number of women mentioned that they are very aware of their gender and sexuality while at work, and reflected on the ways they use themselves as tools in their work. Participant 2 said,

You have to be really strong. . . . You have to be someone who sees yourself as a much more complicated, deep part of the culture than just being a sex object. And it can help a woman find herself and educate herself as to what a powerful person she is but it can be a rough road doing it that way. I feel like a residential setting is great for someone who knows how complicated it is to be a woman in an environment where you have to tell really difficult teenagers what to do, and

not use your sexuality as power, but to stay consistent and kind of sidestep, and be aware of the boys' tendency to sexualize women.

Participant 6 explained her perspective on this unique aspect of being a woman:

Females have to watch what they're doing at all times with the students. You know, it's a delicate balance between mothering them, becoming their friend, but also being an authoritative figure to them. So it's all in finding a balance between it all, and then just riding that fine line.

Participant 13 spoke about the acute awareness of her gender. She stated,

What is unique is that there often times where you are in a room, and you can look around, and you know that you are the only female in that room. And it's full of children, it's full of other male staff, and although you have things in common with everyone, no one has that in common with you. . . . There are instances in which you just become aware that you are the only female, and they look to you to speak on behalf of all females.

The participants were also asked to reflect on how their racial identity affected their workplace experiences. Three of the four participants of color disclosed feeling that they were viewed through a lens of racial stereotypes. Two of the women specifically spoke about their co-workers reacting to them in certain ways because of their races.

Participant 3 described harsh experiences of racial harassment, and one particularly painful incident in which a program director referred to her using a racial slur. She stated,

I think for me I had what you would call a "double whammy" because I'm a female and I'm of minority descent as well. For some people—I think that they would openly talk about the fact that I was young and Latino and female and making more money than some of the male staff. That seemed to bother some people. . . . In some ways, it was harder to be Latino than it was to be a female.

Participant 11 noted the ways in which her authority as a clinical director, and as a woman of color, was received:

It's also a white dominated field, so there's not a lot of people of color who are in these high positions. So I think it's also a double-edged sword for people taking directives from me. Not only am I a woman, but I'm a woman of color. And so I

think that takes them from left field, all the way. And they have their own stereotypes about my color and who I am, because I get asked a lot of questions around my color, around my ethnicity, so they often times make a lot of assumptions.

Two white participants, both clinicians, recognized their privilege. About her racial identity, Participant 2 shared,

It had nothing to do with [my experience], and it had everything to do with it. Being a white female has nothing to do with how I do my job, and being a white female has everything to do with how I am perceived and how I do my job, and how I've built my internal structure of who I am.

More specifically, Participant 1 referred to the “double whammy” concept, and referenced negative stereotypes that often plague women of color. She stated,

I feel like being a Caucasian woman, I'm probably afforded a lot more opportunities, and, as unfortunate as it is to say this, probably a lot more respect and credibility when I speak to something, when I set those boundaries, when I said, “You don't call me that, you don't do this.” I feel that it does hold more weight by virtue of the fact that I was born a Caucasian woman and not a woman of minority.

Three participants noted that residents of their race seemed to gravitate to them because of the similarity of their skin color. One participant was biracial, and the other two were white. Participant 8, who identified as biracial, noted, “Being brown, I think that's a bigger thing than being female.” She felt that the “brown kids” trusted her a little more because of the color of her skin. She said, “They just think, ‘Oh, you can relate to me because you know a little bit more’ – whether I do or not.” Participant 13, who is white, said, “I think kids, I think people in general gravitate to people like them.”

Overall Impressions of Gender at Work

Eight participants (61.5%) identified ways in which being a woman helped their positions at work. All of these responses were in reference to working with the residents. They pointed to an otherwise macho environment, and recognized their presence as

softening the atmosphere of the milieu. The participants believed that residents were able to authentically connect with them more easily, and to allow themselves to be more emotionally vulnerable. Participant 12 spoke about the aspects of the job that make her happy she is a female. She said,

A lot of the kids feel they can come to me, and aren't scared or embarrassed to say what they have to say. Or like, I have one resident who's scared of needles. He wouldn't go on his med run unless I took him. And you know, this is like his third or fourth time that he's asked me to go and take him because he doesn't want to cry in front of anybody else besides me. And that makes me love the fact that I'm a woman there, that some of these dudes know it's okay to cry and show these emotions the right way and express them correctly, and not get made fun of for it. Or being told to man up, or something like that. So that's a part I do love, and it does help being a woman.

Participant 5 reported,

I can think of numerous times when I've brought kids into my office to talk and they've been, you know, really irritating and kind of thug-like when they're out on the floor, and they come in and I just see the little boy side to them. And I think they just, they're comfortable letting that façade down and just being themselves, and talking to me about how afraid they are, and how concerned they are about their future. Then they go back out and, you know, they have to toughen back up to put on this face for the other kids. I'm glad that there's at least some time with me that they can express themselves a little more honestly.

Participant 1 also referred to the environment, and how she saw her gender and her role as beneficial to the residents:

It gives kids something different to respond to. Sometimes the tenor on the unit can be all about exerting control. Control and power. . . . I feel like being a woman here has given kids an avenue to go to when they feel like the testosterone's too high here, when people are too worried about machismo and power and control.

Five participants (38.5%) also referenced aspects of being female that hinder their positions at work. Three of these women noted that being women made it more difficult to work in the facility. The participants talked about traditional gender stereotypes of men in positions of power, and women as more submissive and weaker. This seemed to

impede the participants' abilities to perform their jobs most effectively. Participant 3 spoke about being a woman in this environment: "It definitely made it a lot harder. I think men were automatically in, so to speak, and listened to, where for me, I felt every day was a battle where I was fighting just to do my job." Participant 11 explained her perspective, saying,

I think what hinders it is just the stereotypes about women not being very strong, or having an attitude, or being a b-i-t-c-h if you're somebody who's assertive and says what's on their mind. I think it hinders me because I think because of my gender, some of the men may think twice or hesitate when I give them a directive. I think if I was a man, they wouldn't.

Participant 13 described an incident in which a resident's behavior was escalating, but was still manageable. Participant 13 was dealing with the situation when a male staff picked up the child and physically moved him. Expressing her frustration, Participant 13 stated,

It didn't allow an opportunity for me to redirect the kid myself. And in speaking with other people, other people are like, "Well that's just how he operates. He's just chauvinistic." Well, that's not okay. That's all well and good for that dude to be chauvinistic or not respect how women do their jobs. That's all well and good, as long as he doesn't come and start affecting my job. He can hold whatever opinions he wants. He can do that, but when he's operating, his actions need to show consistency and respect for all of his co-workers.

In their closing remarks, six participants talked about a difficult aspect of their workplace experience. Participant 12 admitted, "It's not really what I expected. I didn't think it was going to be as abusive as it is. I didn't think I would need the thick skin that you do need to work in this kind of environment." Participant 3 stated, "I didn't feel like I had a voice." She again referred to the incident in which a superior referred to her using a racial slur. She said,

I think that was one of the worst experiences I've had, because I felt I'd been violated in so many ways. Before that incident, I went to work, and I was [Participant 3] and I had my struggles, and I was just the person that I was. But after that incident, it was like, "Okay, I'm this Latino person working here." I just felt like I wore my skin. Yeah. Like I was just wearing my skin.

Four participants mentioned that, although the work was challenging, it was enjoyable and satisfying. Participant 8 said, "It's pretty intense. I really enjoy it."

Participant 11 explained,

I really enjoy my work. I love working with the guys. Forget about the farts and the yawning and the burps, or the side comments, I really enjoy my job. And I think not everybody who's female can work in that setting. I mean, you have to really be made of a certain cloth I think to put up with some of the difficult—or, obstacles that come in your way.

Participant 5 shared her perspective:

It's very manageable and I think a lot of the respect that you get back from the men you work with depends on the respect that you give them. And you know, you have to do a little more work, I think, to find a level ground on which you can communicate with them, but it's worth the effort you put into it. And I think more of the men are respectful and considerate than aren't, so that helps a lot. It's definitely worth the energy that goes into it.

Three participants talked about the culture of the agency having much to do with their experience and with the overall tenor of the facility. Participant 7 talked about the general feeling of her agency, and shared,

I think because of what we deal with, and what we need to teach the kids, there's a real consciousness of appropriate behaviors. And not that everybody always does here, but it's supported by the agency, so it's pretty easy to work here.

Participant 3 talked about the culture of her agency being shaped by "old school white guys" who allowed certain racist and sexist ideals to be perpetuated. She said, "I felt like, if that's your leader, it has to permeate throughout the entire program." Similarly,

Participant 2 spoke about her experience of the agency:

I think that there is a fight that happens between the culture of people who are really educated around sexism and gender issues, and people who walk into those jobs never being exposed to that. That's where the tension lay, not with the clients. The kids just want to be loved. I mean, they just want to be treated with respect. I have found across the board that it has been so much easier to develop relationships that are complicated and real with the kids than it is with the staff. And one of the reasons why it really always bothered me is because we inherit what our caretakers give us. So I felt like that kind of absence of awareness in some of the staff could have been inherited by the kids, and that really bothered me.

CHAPTER V

DISCUSSION

This study was intended to give voice to women's experiences working in residential treatment facilities that serve adolescent males. To better understand this unstudied group of women, and to contribute to the body of research on factors that affect the effectiveness of residential treatment, this researcher sought to answer the following questions: How do gender stereotypes affect women's experiences, and how do women feel they are perceived by their co-workers and the residents with whom they work? This chapter will reflect on the findings within the context of existing research, consider the strengths and limitations of the study, and discuss implications of the study for clinical social work and suggestions for future research.

Review of the Findings

An overwhelming theme across women's experiences in this study was the expectation, both of themselves and by co-workers, to "mother" or nurture the residents. In their responses, the participants frequently contrasted this with male staff's tendency to reject emotional expressions that do not include anger or aggression. The idea of sex role spillover (Welsh, 1999) takes a more complex form in the residential treatment setting, as women's socially prescribed gender roles do not necessarily take precedence over their work roles, but do coincide with their work roles. Staff members in residential treatment facilities are responsible for the safety, care, discipline, and treatment of the residents. Thus, it can be difficult to determine whether socially prescribed gender roles are being

recreated in the workplace, or if women are simply carrying out their workplace requirements (Moses, 2000a; Pazaratz, 2003; Stein, 1995). As Jost and Kay (2005) proposed, this role justification occurs when a gender group is perceived to be well-suited to occupy the positions prescribed to them by society, in turn portraying the division of labor as fair and natural.

When ranked hierarchically, in residential treatment facilities and in greater contexts, men and women rate gender roles stereotypically associated with females as less valuable than those typically associated with males (Lev, 2004). The dichotomous expectation of how male and female staff will perform their work duties in residential facilities, while seemingly benign, sets women up to be devalued in this male-dominated environment, where physical safety is a central concern and physical strength is often more highly regarded than emotional strength. The subjectively positive stereotype or expectation of women to be compassionate and nurturing can also reinforce subordination (Burgess & Borgida, 1999; Fiske & Lee, 2008). Participants in the study explained that they felt that, in order to earn respect from other staff, they needed to work harder to prove their emotional stability and to counter the idea that sensitivity to emotions is a sign of weakness.

Participants expressed a keen awareness as to how their being female may be perceived by male co-workers and residents. As in other male-dominated workplaces, their status as women was sometimes emphasized over their status as workers (Welsh, 1999). Conversely, participants' testimonies suggested a lack of awareness by male staff of how their physical presentation and emotional limitations might affect the residents. According to the participants, male staff's attire was not monitored like female staff's

dress was, and they didn't consider that residents could be stimulated by their appearance. Also, participants seemed to identify the stereotypical process of teaching boys that they should suppress or hide the gentle, more vulnerable sides of themselves (Kimmel, 2000; Pollack, 1998). The women saw themselves as emotional havens for the residents who were encouraged to disown or feel ashamed of sadness, fear, and need.

Participants also spoke about the highly sexualized nature of the environment. Most participants agreed that, by monitoring the clothes they wear and the boundaries they assert, they take precautions to lessen the possibility of being viewed as sex objects. The participants seemed confident about being able to identify male residents' behaviors that would absolutely not be tolerated, and how to manage such situations so the residents wouldn't feel a sense of power over the women. There was a striking disparity, however, between the ways in which participants talked about sexually inappropriate behaviors and comments by residents, and those made by male co-workers. As McCabe and Hardman (2005) explained, sexual harassment often becomes normalized in sexually charged workplaces. Participants seemed to have a much harder time identifying what was and was not acceptable, reflecting on the perpetrators' intentions. This reflected what sexual harassment researchers (Goldman et al., 2006; Neville, 1999; Welsh, 1999) have found: Individuals report being the targets of unwanted sexual behaviors, but infrequently label this behavior as sexual harassment.

Some participants noted the inappropriateness of sexual behaviors initiated by male staff, echoing Powers (1993) statement that sexual or seductive behaviors in the vicinity of children may make sexual behaviors more pronounced among the youth in residence. It is understandable and appropriate for residents' behaviors to be more

stringently monitored, as they are there to receive treatment. However, when male staff practice the same condemned behaviors, it sends the residents mixed messages as to what is and is not acceptable, both in the treatment setting and on a broader, interpersonal level. This conflicts with a major goal of resident treatment, which is to provide suitable role models of healthy behavior and respectful communication (Gilliland-Mallo, 1986; Pazaratz, 2003; Prescott, 2001; Stein, 1995).

A few important factors affected women's experiences as employees of residential treatment facilities for adolescent males. The participants who had worked in the field, and specifically in residential treatment, for many years reported feeling as though the way co-workers and residents perceived and treated them had less to do with their gender and more to do with their years of experience. Some participants of color also mentioned that they felt, in some ways, that their race was more significant in their experiences than their gender. Participants' roles at the facilities also contributed greatly to their reported experiences. A number of women in clinical positions noted that it was more acceptable to be female as a clinician, as their role requirements were compatible with gender stereotypes. Women in direct care positions recognized that they were more in the numerical minority, and reported different types of experiences. Finally, participants also noted the compulsive heterosexuality present in their facilities. While the environment is full of sexual energy, deviations from heterosexual norms were fervently disparaged.

Limitations and Generalizability

One of the limitations of this study stems from the snowball method of recruitment and sampling, which limited the individuals who were invited to participate

to those who received the recruitment e-mail. The sample, therefore, drew participants from only New Jersey and Massachusetts. As the names of the employing agencies were not asked of the participants, and the sample was obtained using a snowball technique, it is possible that multiple participants worked for the same agency. While each participant certainly had her own unique experience, the environment and the norms of an agency affected participants' experiences. Having multiple participants from the same agency could have skewed the results.

Also, the measurement instrument was created and used for the first in this project, so its reliability has not been tested. This limits the generalizability of the results. Regarding the instrument, some may have interpreted the language differently than others. Some participants, depending on the gender make-up of the staff in their agencies, seemed to assume that the words "male staff" referred to direct care workers. Conversely, when they used the words "direct care staff," some seemed to be referring only to male staff.

Interviews were conducted over the phone. While there are strengths and weaknesses that may be associated with this method, the lack of personal contact created by using the phone may have caused some participants to feel disconnected or inhibited. This could have prevented them from revealing some uncomfortable information. Finally, the researcher's own background working in a residential treatment facility may have affected the impartiality of the study. Although the researcher did not reveal her own experiences to the participants before the interviews, it is possible that she may have had some biases in forming the interview questions and analyzing the data.

Strengths

A major strength of the study was that it used qualitative methods to collect data from the participants. The participants were able to contribute to this exploratory study by providing rich, meaningful narratives, and expand the scope of understanding of women's experiences working in residential treatment facilities. While conducting interviews over the phone may have inhibited some participants, it may have helped others feel more anonymous and less exposed, and perhaps more comfortable revealing sensitive information. Also, the researcher and the participants were not able to see one another, which could have helped elicit more honest responses from participants and allowed for less bias in the analysis of the interviews. Although the study was only able to include 12 participants, there was a range of ages, years of experience, racial identities, and job positions represented in the sample.

The researcher was aware of her potential biases, and implemented a few safeguards to reduce partiality throughout the study. To minimize potential bias in the interviews, the researcher used a structured measurement tool that was reviewed by others for objectivity. Also, three other readers reviewed the transcribed interviews to validate the themes and findings. The researcher's personal experience may have also served as a strength, as it helped inform the specifics of the interview questions, and facilitated an understanding of some of the intricacies of residential treatment facilities.

Implications for Clinical Social Work

This study revealed that residential treatment facilities for adolescent males are workplaces where gender inequality has quietly persisted. Gender and sexuality are ever-present in this milieu because of the population served and the developmental stage of the

residents. According to the findings of the study and the research on residential treatment, these important dynamics are not being addressed in residential facilities. The ways in which female staff experience their workplaces and their co-workers contribute to both their job satisfaction and the quality of work they are able to produce. The effectiveness of residential treatment facilities, designed to provide a corrective emotional experience in a safe and predictable environment, is compromised at its most basic level if gender dynamics are not addressed. While unprofessional conduct between staff exists, while women feel targeted because of their gender, and while the tasks and duties are so sharply divided by gender roles, these invisible dynamics of the milieu negatively affect the quality of treatment that may be provided.

Administrators must pay specific attention to a few influential ingredients of the culture of the agency. They must be aware of the power dynamics that exist between the residential, clinical, and educational parts of the program. Hierarchical tension, and groups of staff vying for the “most important” part of the treatment, take the focus off of the residents and compromises the treatment. Each program element is responsible for a critical component of the treatment, and should be recognized and valued for its contribution. If this is a value held by administrators, and is genuinely conveyed throughout the program, staff will feel more respected, and the residents will respond to the communal, shared group atmosphere. Also, administrators must notice the way rules and protocols are implemented across genders, ensuring equal enforcement. Allowing male staff to disregard certain regulations while closely monitoring female staff’s compliance sends the message that one group holds more clout than the other. This translates to the ways in which residents regard male and female staff. To maintain an

environment that fosters equality and respect, male and female staff's dress requirements and job responsibilities should be diligently supervised.

The implementation of useful and relevant training must become a major focus. While program policy trainings are important, the translation into practice seems to be missing in many cases. Trainings should be intentionally designed to include and speak to male and female staff. They should address staff as both employees and as implementers of treatment, thereby speaking to inter-staff issues as well as issues with residents. Navigating gender roles, having an awareness of boundaries, and maintaining appropriate conduct should be explicitly portrayed as the responsibility of all staff, and not just female staff. The sexually charged environment must also be recognized. Trainings should be designed to focus on how to manage the residents' sexualized behavior, and what types of emotions might be evoked in staff members. As education levels vary greatly across staff in residential facilities, it is important to account for staff's familiarity, or lack of familiarity, with social issues like gender and sexuality. While it is critical for male staff to understand their responsibility in maintaining a respectful environment, it may also be useful for agencies to create a consistent space where female staff could rely on experiencing safety and solidarity. This could take the shape of a committee or a support group dedicated to espousing gender equality in this unique work environment. The social work profession must attend to these gaps in training and practice to provide an atmosphere of safety and consistency to the emotionally fragile adolescents being served.

Implications for Future Research

As previously mentioned, researchers have not explored women's experiences working in residential treatment facilities with adolescent males. The data gathered in this study suggest that gender is a central component of the environment, and will be important in understanding how to improve both women's workplace experiences and the effectiveness of residential treatment. A larger-scale study incorporating more participants would give a clearer and more comprehensive impression of what women are experiencing in this environment. Since women's experiences varied according to their roles, studies might examine women in clinical positions separately from women in direct care positions. Additionally, in future research it may be helpful to know which participant works at which agency, so as to better understand how the individual agencies foster different cultures.

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Appendix A

Recruitment Instrument – E-mail

Hello,

I am looking to interview women who work or have worked full-time in a residential treatment facility for adolescent males within the last two years, and would be willing to talk about their experiences. This is part of my thesis work for my Master's in Social Work. Participation in this research will contribute to giving voice to women's experiences in this particular work environment, and would be greatly appreciated!

Participation will involve a phone interview that will last approximately 30-60 minutes. Confidentiality is assured and participants have the right to withdraw at any time. If this applies to you and you're interested, please email me at -----@gmail.com or call (203) 517-3342 as soon as possible. If you know of someone who might be willing to participate in this research, please feel free to forward this e-mail or to send me her email address.

Thank you very much for your help!
Jessica Donohue

Appendix B

Screening Questions

- Are you female?
- Are you over the age of 18?
- Are you fluent in English?
- Do you work full-time in a residential treatment facility? or Have you worked full-time in a residential treatment facility within the last two years?
- Are you a direct care worker or a clinician?
- Does your residential treatment facility serve males between the ages of 11 and 18?
- Do you/Did you work full-time with only male residents?
- Have you worked in the residential treatment facility for at least 9 months?

Appendix C

Informed Consent Form

Dear Participant,

My name is Jessica Donohue and I am a second year Master's in Social Work candidate at Smith College. In order to complete my Master's Degree, I am conducting a research study for my thesis. The research is designed to understand the experiences of women who work in residential treatment facilities for adolescent males. The information collected during the process of this study will be used to complete this thesis project. The findings will later be shared in a presentation of the project, and possibly in other presentations, and may be submitted for publication at a later date.

For this study, I am looking for women who are over the age of 18 who are fluent in English. Participants must be employed full-time in a residential treatment facility, or must have worked full-time in a residential treatment facility within the last two years as either direct care staff or as a clinician. The treatment facility must serve a population that includes adolescent males between the ages of 11 and 18. Participants must work or must have worked full-time with only male residents. At the time of the interview, participants must have worked in the residential milieu for a minimum of nine months. If you decide to participate in this study, I will ask you to participate in a phone interview with me at a time that's convenient for you, when you are not at work. The interview will most likely last between 30 minutes and 1 hour, and will be audio taped. I will ask you some demographic questions, and questions about your experiences as a female employee in your specific workplace. Afterwards, I will transcribe the interview.

Since this interview asks for personal experiences at work, participation may elicit some emotional discomfort for some. All information obtained in the interview process will be held in strictest confidence, and participants may be assured that I will not ask for the names of their employers. In the case that you feel the need for further support upon the completion of the study, I will be happy to provide you with a list of referral resources.

Participating in this study will provide women with the opportunity to share experiences they have had working in residential treatment facilities with adolescent males. You will be given the opportunity to reflect on your experiences. Participants may feel a greater sense of self-awareness or gain insight into their experiences as women working in this specific environment. Participation will also help contribute to the development of knowledge about residential treatment facilities and women's workplace experiences. There will be no financial compensation for participation in this study.

I will do everything in my capability to keep all information from this study confidential. Your name and any personal descriptors will be removed from the data when I transcribe the audiotape. Each participant's interview will be assigned a number code, and the name will no longer be connected. Since I am a student, I have an advisor for this

research study who will have access to the data once the names have been coded, but who is also dedicated to honoring your confidentiality. In the future, I will prepare the data for any presentations and publications in such a way that participants will not be individually identifiable. If brief quotes or vignettes are used, they will be carefully disguised to protect your identity. All data from the interviews (audiotapes, notes, transcriptions) will be kept in a secure location for three years, as required by Federal regulations. Should I need the material for further research beyond three years, they will continue to be kept in a secure location and will be destroyed when they are no longer needed.

Although your participation would be helpful and appreciated, your participation is completely voluntary. You are in no way obligated to participate, and you may withdraw at any time before, during or after the interview. You may refuse to answer any question without penalty. If you choose to withdraw after the interview, you may withdraw from the study until March 15, 2009. If you choose to withdraw, all data pertaining to you will be excluded. After this date, however, it will be impossible to remove material from the study, as the report will be finalized. If you have any additional questions, or if you wish to withdraw, please feel free to contact me by phone at (203) 517-3342, or by email at -----@gmail.com. If you have any concerns about your rights or about any aspect of the study, you may reach me at the phone number or email address listed above, or you may contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Participant's Signature

Date

Researcher's Signature

Date

Please keep one copy of this form for your records. If you have any questions, or wish to withdraw your consent, please contact:

Jessica Donohue
(203) 517-3342
-----@gmail.com

Thank you for your participation.

Appendix D
HSR Approval Letter

January 12, 2009

Jessica Donohue

Dear Jessica,

Your revised materials have been reviewed and all is now in order. We are happy to give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Joan Laird, Research Advisor

Appendix E

Interview Guide

Code #: _____

- How old are you?
- What is your racial or ethnic identity?
- How long have you been employed at your agency? or How long were you employed at your agency?
- What is/was your job title/description?
- In what area of the country is your agency located?

- What tasks or duties are you responsible for within the group of staff you work with? Do you think these duties have anything to do with your gender?
- Do you think that being a woman affect your opportunities at work in any way, in terms of advancement or special assignments or otherwise? How?
- Does your agency provide any training specifically having to do with gender? If so, what are your reactions to the training?
- Are you expected or asked to wear/not wear anything in particular to work? How does this compare to what male staff are expected or asked to wear?
- What types of expectations do you feel male staff have of you?
- What types of expectations do you feel other female staff have of you?
- How do you feel male staff perceive your competence as a fellow staff member?
- How do you think the kids act towards you compared to how they act towards male staff?
- Sometimes kids make sexually charged comments. How are comments aimed at female staff different/similar to comments aimed at male staff? How is this handled by your agency and co-workers?
- Have you ever experienced a male co-worker touching you in a way that made you feel uncomfortable, asking you about sexual relationships, or making sexual jokes or references? If yes, can you describe such an incident?
 - If yes, did you complain? To whom did you complain? What was done about it? How was it handled?

- How does being a woman help or hinder your position at work? What experience stands out the most to you?
- What is unique about being a woman working in this specific environment?
- Do you think your racial identity makes a difference in your experiences?
- Is there anything else you'd like to share about your experience as a woman working in a residential facility for adolescent males?

