Journal of Child and Youth Care Work

CREATIVE TREATMENT PLANNING AT A GROUP HOME FOR TROUBLED ADOLESCENTS

Cynthia Davis
Batshaw Youth and Family Centers
Montreal, Quebec, Canada

ABSTRACT: This article is intended to explain the theory and practice of the creative treatment plans used at a group home which provides residential and day treatment to adolescents in difficulty. The first section reviews theoretical influences and their applications, and the second section discusses the elements involved in writing treatment plans. Treatment plans at the group home are designed individually to use themes or metaphors which are meaningful to each client. Theories explored are Applied Behavioral Analysis, Strategic/Systems Therapy and Narrative Therapy. The steps to writing treatment plans are explained and a sample plan is provided .

KEY WORDS: creative treatment planning, residential treatment of adolescents, applied behavioral analysis

Creative treatment plans at a specialized group home are designed with unique themes or metaphors to make them meaningful for each client. If a client has an affinity or an aptitude for, say, swimming or poetry or butterflies, the plan will be built around that theme. Each plan has specific cues that address the clients' challenges and strengths.

The treatment plans are part of a team approach to treating adolescents in difficulty. The players on the team are the staff, the teens, and the families. The treatment plans help to organize the responses of the team to the clients in order to help solve their problems. The creative treatment plans are also the key in connecting the work the client does in the unit and at home.

The creative treatment plans were created in a specialized residential and day program which was developed to provide intensive therapeutic service to youth (aged 13 to 18) with psychological problems and a specific psychiatric and/or medical component to their difficulties. For example, some clients have been diagnosed with Borderline Personality Disorder

The names and identifying information in the examples have been changed to protect the confidentiality of the clients. Examples are used with the written consent of the clients.

Thank you for the helpful comments and suggestions to the following readers: Patrick Carlon, Dr. Brian Hunt, Francine Levèsque, GloriaJean Murphy, Brian McGirr, Julia Paré, and Debbie Walsh.

Correspondence concerning this article should be addressed to Cynthia Davis, Bourbonniere Unit, Batshaw Youth and Family Center, 6 Weredale Park, Westmount, Quebec, Canada, H3Z 1Y6. E-mail: Cynthie_Davis@ssss.gouv.qc.ca

and many have a history of self-injury. Clients may suffer from depression, phobias, eating disorders, and other disorders (see Lothian, 1991, for a description of the program and treatment strategies by a founder of the group home).

PART 1 - THEORY

The main theoretical sources that inform the treatment planning are Applied Behavioral Analysis, Strategic/Systems Therapy, and Narrative Therapy.

Applied Behavioral Analysis

Often, clients are unwittingly rewarded instead of given negative consequences for unhealthy behaviors. In youth care, the most common reward for maladaptive behavior is individual attention or counseling. When clients act out, they often receive the undivided attention of one or more staff to "process" (receive counseling about) the behaviors. Regardless of the content of the discussion, or the other consequences associated with the transgression, the one to one attention serves as a reward for many clients, and may increase the occurrence of the behavior.

Applied Behavioral Analysis (ABA) helps us to analyze behaviors and the responses that maintain or reduce them. It was developed when O. I. Lovaas (1987) applied principles of basic behavioral theory to individuals with developmental delays. The fundamentals of his approach are applicable to many populations with behavioral challenges, including those without developmental delays. We apply the principles to understand and resolve the behavioral problems of teenagers.

In ABA, the antecedent of a behavior, the behavior, and the consequence are analyzed. The antecedent is the situation or event that immediately preceded the behavior. The behavior is what the person did. The consequence is the response of other people to the behavior. The consequence can be positive or negative. The way to judge whether the consequence is positive or negative is by how it affects the behavior. If a consequence is positive, the behavior is likely to increase. If a consequence is negative, the behavior is likely to decrease. In behavioral literature, this is referred to as the "Law of Effect" (Thorndike, 1911). Just because we assume a consequence is negative or positive doesn't mean that the assumption is correct. For example, a teen at the group home had the chore of putting the dishes away. He was in the middle of an exciting computer game when the group leader asked him to do his chore (antecedent). He went to the kitchen and tossed the dishes roughly into the sink, almost breaking some of them (behavior). The cook gave him a lecture, took the dishes from him, and kicked him out of the kitchen (consequence).

This consequence got him attention from the cook, who he adored, plus he got out of doing his chore. In this case, the consequence was positive

as it was likely that the young fellow would be no more careful with the dishes in the future.

An example of a negative consequence for that behavior would be if the cook ignored the boy and an educator made him re-do his dishes plus clean everyone else's dishes.

Strategic/Systems Therapy

Strategic/Systems Therapy is a branch of family therapy in which the family is viewed as a system, and strategies are used to bring about changes. Bateson (1980), Haley (1976), and Minuchin (1974) are developers of this approach. According to Chloe Madanes (1981), "strategic family therapy developed from a concern with power in the relationship between therapist and client and in the relationship among the members of a family. Strategies of psychotherapy were developed to utilize this power in order to produce change" (p. xxi). Some features of this approach that inform our practice are:

- The family is viewed as a system in which each person affects the whole, and a change in one person has an impact on the whole system.
- The therapists take responsibility for solving the problem. When the problem is not successfully solved, it is the therapist's responsibility. When the problem is resolved, all credit for success goes to the clients and their families.
- The emphasis is more on problems and solutions than on past trauma or insight.
- Problems may be reframed to be seen in a more sympathetic way.
- Directives are given, and some of them may be paradoxical (for example, prescribing some element of the symptom in order to gain control of it, like having an overly perfectionist client make one mistake per day).
- The family hierarchy is examined and corrected if necessary.

Narrative Therapy

In their book, Narrative Means to Therapeutic Ends, Epston and White (1990) write: "Externalizing is an approach to therapy that encourages persons to objectify and, at times, to personify the problems that they experience as oppressive" (p. 38).

Some of the innovations of Epston and White are routinely put into practice at the group home, particularly externalization of the problems and using documents in the service of the clients.

Externalization. Some clients' inner battles are so overwhelming that it is hard for them to get through the day. One strategy that is often helpful for these clients is to externalize the battle in order to help them fight against their symptoms. The symptom is personified as a monster, vampire,

or enemy that is trying to deprive them of all that life has to offer. The treatment plan is used as a tool to attack problems instead of identifying with them.

Therapeutic use of the document. Documents are written for the benefit of the clients and their families. They are written so as to offer hope, encouragement, understanding, and solutions. They may show the symptom in a more positive way, as an attempt to problem-solve. The treatment plan histories (see below) and the treatment plans are written as therapeutic documents.

PART 2 - WRITING TREATMENT PLANS

Why Treatment Plans?

The main value of treatment plans for clients in a group home setting is to ensure that they are responded to in ways that are consistent and that address their difficulties. In other words, all of the people in their lives give them reinforcement for their strengths and negative consequences for their maladaptive behaviors. The goals of the plans are to solve or reduce the behavioral problems that the clients present with.

Steps

There are several steps involved in writing a creative treatment plan. The following is a description of the steps and the process used to create the plans.

Observation period. During the observation period, the clients and staff will learn about the challenges and strengths of the newcomer. They will notice behavior patterns which bother people, ways of coping with stress, and skills at adapting to a new situation. They will also learn about the particular interests of the newcomer. Time in the community is restricted during the observation period. The observation period lasts about three to five weeks.

Client group feedback. Once the newcomer has settled in and the group has gotten to know her a bit, the clients will be asked to give their feedback at a client group meeting (the client group meets twice daily to work on treatment issues). One of the clients will record the impressions of the group. The staff ensure that the experience is as positive and constructive as possible. In general, the teens are quite generous and offer their comments in a supportive way.

Timeline. During the observation period, the new client is asked to create a timeline representing important events that happened in his life. The goals of the timeline include understanding the origins of the symptoms and engaging the client by aligning with the person and not the symptoms.

The young person is given an 18 in. by 24 in. paper and drawing supplies and asked to draw a line representing her life through time. She can start it at birth, or even before if major family events occurred before she was born. She plots the year and her age on the timeline. She continues the line through the years and writes such things as the birth of siblings, moves, schools, changes in the family situation, illnesses, hospitalizations, and so forth. Most of the young people we deal with have had considerable upheaval in their lives, and these events are plotted on the timeline. Once the time line is done, the youth is asked to go over the events and describe how she coped with the various events. We find that many coping mechanisms that have become maladaptive began as creative ways to deal with difficult situations.

Treatment plan history. The information in the timeline is used to write a treatment plan history. This is a brief history of the events in the client's life told from her own perspective. Optimally, it includes the history of the symptom and the youth's own desire to reclaim her life from the symptom.

The treatment plan history is written by the Art Therapist/Treatment Plan Coordinator, based on the information given by the client. Several drafts may be written, as each draft requires the approval of the client. Sometimes, discussing the events or the drafts of the treatment plan histories leads to the sharing of more information, which is then included in the next draft of the history. The writing of the treatment plan histories is considered a therapeutic intervention, as is every step of the treatment planning. Every word is written for the benefit of the client and his family. Nonjudgmental language is used throughout.

Initial draft of treatment plan. All of the above is taken into account when writing the initial draft of the treatment plan. The plan is written with the client's ideas and cooperation and they are consulted and contribute to the whole process. Often, they become very excited as the plans take shape, and they see themselves as the main architects of their own plans.

Introduction. The introduction sets the therapeutic tone of the treatment plan. The information in the treatment plan history, the observations of the staff, and the feedback of the clients and the parents are taken into account in deciding on the main theme of the plan. This is explained in a sympathetic way in the introduction.

Themes. Each treatment plan has a theme that is suited individually to the client. Therefore, no two treatment plans are ever the same. The clients help to develop the theme by stating their interests. Some clients come up with their entire plans by themselves after observing the other clients' plans. Ideas are also solicited from peers and the staff. Examples of themes taken from the clients' interests include: skating, kickboxing, swimming, computers, guitar playing, painting, and drama. Examples of themes from plans in which the inner battle has been externalized include fighting against: Anorexia, The Dragon, The Evil Twin, The Shadow, and The Obsession Monster.

Cues. Most treatment plans have three cues to help redirect the clients' behaviors. The first cue is usually a warning that the behavior is present. The client is then given the chance to immediately correct their behavior. The second cue is generally used when the client fails to respond adequately to the first cue. The second cue may signal that they have to separate themselves from the group and do a task such as a soothing technique. The third cue is usually the signal that desired behaviors are present. The cues are individually suited to the client and the treatment plan. Usually, they make up their own cues. When they contribute in this way, they experience more ownership of the plans.

The following is an example of a plan that helped a 14 year old girl from a family with many difficulties gain control of her behavior. The team nurse came up with the idea of using Tara's beloved butterflies to represent transformation.

TARA – BUTTERFLY TREATMENT PLAN

Tara is in the process of evolving from a (sometimes) anxious and dependent girl into an independent, mature, and responsible young woman. She has a butterfly plan to help her with her transformation.

Caterpillar Phase

The caterpillar represents Tara's less evolved behaviors. When Tara displays the following behaviors or characteristics, she is in her caterpillar phase:

- Shyness preventing her from communicating
- Overly dependant
- Overwhelming anxiety
- Temper tantrums
- Refusing to go to school
- Refusing to do what is asked of her (i.e., chores, getting off of the phone or computer, going to bed when mom asks, etc.)
- Other immature behaviors

When anyone notices any of these behaviors, they will ask Tara if she is "CRAWLING", or tell her she is crawling.

Tara may immediately correct her behavior. If she continues to crawl, Tara will be told to go to her "COCOON".

When Tara is told to go to her cocoon, she will go to the conference room (or another designated area) and work on "transforming". She will do this by developing **ten techniques** she can use to calm and soothe herself and address the issue. She will spend a minimum of 10 and maximum of 20 minutes working on her techniques.

Tara may request to go to her cocoon at any time that she needs to.

Butterfly Phase

While in her cocoon, Tara will work on becoming like a butterfly. The butterfly represents Tara's mature and independent state. Tara is in her butterfly phase when the following behaviors or characteristics are present:

- Socializing with others
- Speaking her mind
- Taking responsibility for her chores
- Being more independent (i.e., not crying when she gets off the phone with her mother)
- Taking good care of herself
- Accepting no's
- Participating with the group
- Coping with her anxiety without misbehaving
- Attending school
- Other mature behaviors

When anyone notices Tara doing any of the above, they are to tell her she is "SOARING".

DISCUSSION

Before Tara came into care, her "less evolved" behaviors resulted in attention from her mother, and being allowed to stay home from school. When we substituted her "crawling" cue as a response to her behaviors, it changed the chain of events. It put the adults in control of the situation, and Tara had to do some work to solve her problem. Changing the consequence reduced the recurrence of the "less evolved" behaviors. Tara's positive cue, "soaring" was used to constantly reinforce her mature behaviors and help her to feel competent.

The family system was involved in helping Tara by using her plan. Her mother was supported for her strength and determination, and her skill at using the plan. She was not blamed for keeping Tara home from school or for any of Tara's problems.

A metaphor based on Tara's interests was used to symbolize her personal evolution. It helped her to identify more with her strengths than with her difficulties.

The clients whose battles have been externalized by the treatment plans have cues which reflect the externalization. For example, a girl whose depression made her feel suicidal had a Shadow Fighting Plan. When she needed to fight the shadow that was attacking her, she was

told, "Shine your light!" When she was doing well, she was told, "Your light is bright!"

While the 3 cues are used in many plans, it should not be read as a menu for writing plans. Each plan must be distinct and relate specifically to the individual. Some plans may have more or fewer cues.

Self-soothing techniques. A self-soothing technique is an activity done individually by the clients to help to calm and focus them when they are in distress. Some of our treatment plans require a daily practice of the techniques to create the habit of doing activities to self-regulate.

Typically, clients are asked to create a repertoire of techniques that are helpful to them. A technique that could benefit one youth could harm another, so they are chosen on the basis of each individual's requirements.

Some examples of soothing techniques are journal writing, colouring, walking around the block, yoga, deep breathing, getting a cup of hot chocolate, reading, playing an instrument, making a collage, beading, biking, and weight lifting.

Activities that require other people, such as counseling or calling friends, are not included. Most of the clients request counseling as one of their techniques, and they are refused. We want them to be able to calm themselves. Counseling is offered regularly by the child care staff, the art therapist, the social worker, and the consultant psychiatrist, but not in response to crises or bad behavior. As discussed above, the individual attention of counseling is considered a reinforcer or reward, and therefore, we try to offer the individual attention of the staff when clients are doing well and achieving their goals.

Indicators. Each client has written indicators that accompany their plans. The indicators are questions which the client must respond to at each client group meeting. The answers are recorded and this data serves as a record of the client's progress. Indicator questions typically ask about the frequency of the use of the treatment plan cues and the handling of treatment issues. The indicators also serve as regular reminders to the client, peer group, and staff of the main issues the client is working on.

Poster, presentations, and role plays. Once the initial draft of the treatment plan is written, it must be approved by the client, the staff, and the client's family. When it has been approved, the client is then required to make a poster illustrating and explaining their plan. They must present the plan and the poster to the client group. The client must also present the plan and the poster to the staff in a weekly staff meeting. The presentations increase the clients' investment and pride in their plans.

The parents are asked to do some role plays of the plan with their child at a family meeting so that they will be comfortable using the plan at home.

Testing. The first couple of weeks of practicing the plans is the test run. Sometimes some problems arise in the execution of the plans. These are corrected as soon as possible.

Revisions. Once the treatment plan is in effect, it should be reviewed and revised if necessary at regular intervals, ideally about every 4 months, to ensure that it is meeting the needs of the clients. If a problem is solved, there is no need to continue working on it. Another problem may be identified, or the plan may be faded as the client integrates back to her home. Fading the plan may involve eliminating some cues, or changing the cues to more commonly used language, for example, saying, "Great job!" instead of "Masterpiece". As they master their difficulties, the clients hear fewer of their warning cues and more and more of their reinforcing cues.

Challenges to youth workers in applying treatment plans. Youth care workers report that the biggest challenge in applying the plans is the initial resistance. Clients regularly test out their treatment plans to see if they will be applied in a consistent fashion. The most common testing is that clients say that the plans were used at the wrong time, for the wrong reason, or that they were used incorrectly. When youth workers become familiar with the plans, they do not fall for that ploy. The clients begin to trust the plans when they see that everyone involved in their treatment knows how to use them.

There may be organizational difficulties in applying this method of working. It requires an organizer and the cooperation of all of the staff. Any staff member who does not like the approach can easily disrupt the functioning of the plans by not applying them or by applying them in an unproductive fashion. Dealing with the resistance of staff as well as clients is part of the job of the treatment plan coordinator.

Adapting the techniques. The simplest and arguably the most important technique to adapt in different settings is the principle of rewarding desired behaviors and limiting attention to unwanted behaviors. Examples of ways to reward desired behaviors are: meeting with a client to tell her what she is doing well; arranging a special outing in recognition of a client's success; and giving the client extra privileges to support responsible behaviors, citing improvements at group meeting. When the team concentrates their time and creativity on rewarding desired behaviors, it creates a positive culture in the unit. Clients learn that they will get a lot of appreciation when they do well, and that helps them to improve their behavior.

CONCLUSION

Creative treatment plans are the main vehicles for working towards change and organizing responses to the group home clients. They focus the therapeutic work and keep the process positive. This model of creative treatment planning is adaptable and teachable and it could be applied to many different points of service. Most of the teens we work with successfully integrate back to their families and to school or work with relief from or reduction of symptoms. Outcome studies are needed to quantify results.

The following are some comments from educators who implement the treatment plans:

"All the plans are playful, use humour, and capture the imagination."

"The use of metaphors allows people to step outside of their habits and patterns of behavior, and view them from a different angle."

"The plans highlight the behaviors being addressed and empower the clients and their families to choose more successful interaction options."

"The creative aspect of the plans helps the clients to own their own behaviors and to assert self control."

References

Bateson, G. (1980). *Mind and nature.* New York: Bantam Books.

Haley, J. (1976). *Problem-solving therapy: New strategies for effective family therapy.* San Francisco: Jossey-Bass.

Lothian, D. (1991). Working with suicidal adolescents and their families. *Journal of Child and Youth Care, 6*(1), 1-9.

Lovaas, O. I. (1987). Behavioral treatment and normal education and intellectual functioning in young autistic children. *Journal of Consulting and Clinical Psychology, 55,* 3–9.

Lovaas, O. I. (2003). *Teaching individuals with developmental delays.* Austin, TX: Pro-Ed.

Madanes, C. (1981). *Strategic family therapy.* San Fransisco: Jossey-Bass.

Minuchin, S. (1974). *Families and family therapy.* Cambridge, MA: Harvard University Press.

Thorndike, E. L. (1911). *Animal intelligence* (chap. V, Laws and hypotheses for behavior). New York: Macmillan.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends.* New York: W. W. Norton & Co.