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VIEWS OF RESIDENTIAL TREATMENT

Letters from
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and

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Dear Richard:

I enjoyed our telephone conversation and I hope my comments about program ideas didn't come across as being judgmental. It would be presumptuous of me to think that I could evaluate the needs of your program with the very little knowledge that I have about it. I do, however, feel strongly, as I know you do, about the sharing of ideas as regards working with very troubled and disturbed children. I would like to elaborate on some of the ideas I mentioned to you on the telephone and I would very much like to get your feedback and your opinion on them. You raised the issue of programs with expertise such as Walker Home and The Children's Home should be committed to taking the most difficult children. I have several thoughts on that and let me share some of them with you.

I'm concerned about children who tax the system the most, and therefore are a high priority because they are "the squeakiest wheels," but they represent a small portion of children needing residential care. Programs like Walker Home, who choose to serve these kids, are without a doubt providing a great service and are dealing with a population that generally most people would rather not deal with. Historically though, group care has not directed its service toward children with this severe psychopathology. Programs such as the Walker Home in the Trieschman era, Starr Commonwealth in Detroit, Bellfaire in Cleveland, The Chil-

dren's Home and most traditional group care settings were not originally set up to work with the types of children you are now taking at Walker. I believe there would need to be a major refocus in group care to educate providers on how to develop programs that can be successful with these children. Also, I believe if we focused exclusively on this population, we would be neglecting a larger population of children that group care can treat more effectively.

These are children who have been severely traumatized by neglect, abuse and abandonment. Attempts to put them in in-home placements with wraparound services have failed. Because of multiple placements, these children are aggressive, unsocialized and most importantly, unattached. They have great potential to become violent and aggressive and will need a hospital type program if, in fact, quality "less restrictive" residential care is not given to them.

What I have been most struck with in the past ten years is that these children are unattached and have no significant person in their life. They are children who have been traumatized by many losses which cause them to withdraw from attachments. Their losses, coupled with abusive and neglective interaction with adults, significantly retards their capacity for healthy object relations. (I have sent an attached write-up of a workshop that I did on both Denver and Valley Forge that talks to some of these concepts.) These unattached children must have a significant adult in their life if they are going to overcome these developmental deficits. They need someone they can incorporate, who they can learn from and who they can become dependent on so that they are able to develop, from that person (through ego lending), a concept of self and the knowledge and desire to control themselves. This process usually occurs from ages 0 through 3, but for these children the process must begin or be restarted at whatever age we begin treatment with them.

I think the 90s will provide us with an even greater number of these children. They are just as difficult as the violent children (not from a physical perspective), and I believe they have a better prognosis. However, residential centers should choose the populations that they feel they can best serve and then focus on the quality of treatment. I am very much aware, however, that funding can dictate the population programs we serve and that often the most violent children are seen as the most "in-need children," even though they may have a guarded prognosis at best. I don't believe severity of psychopathology (which is generally equated with acting out) is the best criteria for determining allocation of funds.

Secondly, the whole issue of the aggressive and violent child and the developmental dynamics associated with these children, is extremely important. When working with them, professionals must look at the psy-

chological, environmental, cognitive, biological and constitutional factors which contribute to their violent and anti-social behavior. You mentioned you were very interested in their cognitive and biological dynamics. Their violent outbursts may be caused by chemical imbalances or organicity such as minimal brain dysfunction. Or, violence can be linked to a cognitive process whereby the child lived in an environment which taught and promoted violent and aggressive behavior and, for that matter, possibly stimulated this behavior by involving the child into physical and violent interactions. The behavior may also be linked to feelings of abandonment and loss which cause the child to be severely depressed. This depression may be acted out and defended against by displaying violent behavior (masked depression) and, at times, it may be a combination of one or all of those I just mentioned.

Professionals providing treatment to these children must perform careful and ongoing assessments to decipher the roots of the violence. Whatever the cause, the end result is a child who is without internal controls, therefore becomes reliant on the environment and the people around him to provide controls. Your mission, as you stated, is to provide those controls with adults who promote a safe holding environment for kids. Aggression is first controlled by physical restraint and then you provide cognitive retraining, which includes redirection and reparenting. These interventions, hopefully, will enable the children to begin to control their aggression so they can then take advantage of treatment you are offering to them. That is why I feel that the primary system or a system similar, would very much benefit the violent and aggressive acting out children that you serve. Such a system is based on normal development and therefore provides the ingredients children need to incorporate controls, whether they are in a normal family environment or a therapeutic group care one. Concept of self, which includes self-esteem, sense of mastery and social skills, contribute to ego functioning (i.e., impulse control). Ego is formed and nurtured through the relationship with a significant adult (mom). Since you advocate that adults will provide the initial external control, why not, as much as possible, have it come from an adult who is responsible for that child's overall treatment, who the child is dependent on? I have to believe that a child care worker who works through these awful, violent storms with "their children" might be seen by those children as an adult who felt they were important and would stay with them despite their behavior. Also, the adult has a special investment in his children and is empowered by being responsible for their treatment.

Children whose aggressive and violent behavior is more chemically based, or organically based, will then be more reliant on external struc-

ture, along with medication, to gain self-control. They will be less likely to benefit from the attachments around them to gain the control. I do feel that these children are the smallest percentage of the population we serve.

On the issue of physical plants, such as the Walker Home and The Children's Home, I feel they are not set up to provide a safe environment for violent children. Therefore, major adjustments would have to be made to the physical plant (or one unit) to be conducive to a more structured and "closed" type of environment, at least until the child is able to deal with less structure and more openness. I think we agreed that the environment (physical plant) has to say to the child "I will control you safely." The contrast between a hospital setting, as compared to Walker Home and The Children's Home, is too dramatic and I don't feel they give violent children that safe message.

In closing, I believe the pioneers in group care, (who have been so eloquently present at the previous Trieschman Conferences) knew that the successful treatment of children would be decided by the program's ability to develop child care workers who could relate (therapeutically) and form relationships (attachments) with the children. It was not discussed in attachment or developmental theory terms, but the field of child development has increased its knowledge greatly since Redl wrote in the 50s and Trieschman in the 70s. But, I believe they were speaking about promoting attachment and giving these children the feeling and perception that they were special to someone. That someone, I believe, is the child care worker who must be skilled to reparent.

I would very much like to get your feedback on some of these ideas. I have been impressed with your commitment to residential care and working with troubled children, but I've been particularly impressed with your genuine attempts to analyze what it is that we do and what it is we need to do to help these extremely difficult children. It comes across clearly when you speak and it also comes across that you urge others to do the same. I will always be indebted to the Walker Home and Trieschman Center for providing child care professionals the encouragement and opportunity to write and share our ideas. I am not sure I would have done so without such a vehicle. I would very much like to continue our dialogue. I look forward to receiving a response and I hope to talk with you soon.

Sincerely,
Jack McElroy
Clinical Director

Mr. Jack R. McElroy, Clinical Director
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Dear Jack:

Many thanks for your wonderfully thought-provoking letter of December 10. As always, I find your ideas challenging; and as always, I find myself partly in agreement and partly ready to argue. Let's go to it!

First of all, I want you to know how much I appreciated the long give-and-take of our recent phone call. You made me realize just how important it is to have opportunities for "live" peer consultation, as opposed to the staged ways we, as professionals, communicate to each other at conferences and such. I also appreciated the personal support.

The fact is, this is a difficult year at Walker School. Having made the conscious commitment in our residence program to adhere to an intake policy of serving the most troubled boys who can safely be maintained outside locked psychiatric settings, we now find ourselves questioning whether the program elements which worked so well in the past are adequate to meet the needs of these children. As I told you on the telephone, I'm looking hard at staffing issues (student/staff ratios, deployment of back-up and oversight resources, training, etc.), the shape of space in our classrooms and living units, the level of basic care and safety we are able to provide, and most of all the usefulness of our long-standing, psychodynamic "working theories" about child development and human behavior. At the most basic level, we are currently struggling to hold on to at least 3 boys whose extreme physical and sexual acting-out has pushed staff to the limit.

Probably the most challenging question you asked, and raised again in your letter, was why are we trying to work with such an extreme population in an open, residential treatment environment? The implication, of course, is how can we really help anybody if we end up "over our heads" with even a few kids we can't handle? I think you are absolutely right that every program has its limits, and it is wrong and dangerous to ask child care workers to care for very troubled youngsters without sufficient program resources. However, I still cannot agree that this comes down to an issue of sorting out, in advance, which kids are "too disturbed" or "too violent" to make it in residential treatment. First, I grow more doubtful every year about the validity of the labels and categories we use to describe the increasingly complicated children coming into our care. More importantly, while I share your view that not all group care settings can or should be geared to intensive treatment, those of us who

claim to provide such treatment, and moreover have the physical resources, have an obligation to reach out to the most troubled children in the system, bar none.

You know how much I respect you and the fine work done at The Children's Home; and you also know that things are far from perfect here at Walker. Even so, I am very uneasy with program models based, even a little bit, on excluding the most troublesome kids because they don't fit.

From another point of view, I do agree with you that residential treatment programs seeking to serve the most severely acting-out children will need to develop a much better understanding of the environmental, psychological, cognitive and constitutional factors associated with violent behavior. I do not agree, however, that children presenting such behavior are in a small minority. My own experience through the Trieschman Center suggests that many group care programs, whether they claim to provide intensive treatment or not, are being asked to deal with increasingly volatile, acting-out youngsters because these are, in fact, a fast growing percentage of all referrals. Like it or not, I believe all of us in residential group care are going to have to adapt our programs—up to and including, as you rightly point out, our architecture and use of space—to deal with the troublesome children we would have excluded in the past. This is difficult, but not impossible; and I have to believe it can be done, while retaining the heart of the Trieschman, Redl, Bettelheim, Mayer, etc. formulations.

Finally, I have been giving a lot of thought to the primary caretaker approach to treatment as you articulate it. In general, it is certainly hard to argue with; and I am very impressed by your emphasis on promoting attachment as a primary developmental goal of treatment. Still, our experience lately at Walker with the various attachment disorders of our children, and some of their parents for that matter, has been sobering. I am very interested in learning more from your implementation of this approach at The Children's Home. I still insist, despite our lively debate on the phone, that a developmental orientation to treatment can go hand-in-hand with a highly structured, behavioral program throughout the environment. We should talk more about this soon.

Thanks again for your willingness to share your advice and your ideas, and for your kind words about the Trieschman Center. I hope to see you again soon.

Warm regards,

Richard W. Small, Ph.D.
Executive Director