The Primary Caretaker Model: A Developmental Model for the Milieu of Children and Adolescents

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Professionals involved in residential caring facilities are waging a war on two fronts: one outside their walls and one within. It is no longer enough to provide quality residential care for significant periods of time to troubled children who cannot be at home. Rather, there is increasing pressure for shorter residential stays or no residential placement, based on the idea of permanency planning and the move toward returning children home as reflected in The Adoption Assistance and Child Welfare Act of 1980 (PL 96–272). The spirit of this act and the current tenor of the times is that placement in a family setting (foster, adoptive, or natural) is almost always preferable to residential care. This is consistent with permanency planning as "a philosophical commitment to the vital role of the family in the child's development" (Maluccio, Fein, Hamilton, Klein & Ward, 1983).

The above stated position is being promulgated despite professionals knowing that "just as some children can remain home while they and their families receive help, others will continue to require total or partial care away from home" (Whittaker, 1979, p.5.). While there has been a clear shift away from residential placement as an alternative to life within a family, however dysfunctional the family or however troubled the youngster, we know from experience that there are those children who are unsuccessful or experience "disruptions" in family placements. Typically, it is after a series of "disruptions" in family placements that these children are then referred for residential treatment.

Given the external pressures to keep children out of residential facilities, or to utilize residential placement mainly for shorter stays so that children can return to families, residential caring facilities are faced with the challenge of attempting to treat children somewhat differently. Increasingly, residential treatment staff are being required to prepare children for return to life with families or to rehabilitate them after disrupted placements so that they can go back into a family setting yet again.

Maluccio, Fein, Hamilton, Sutton and Ward (1982, p. 98) state, "It is important that staff members of child care institutions and residential treatment center be attuned to the permanency planning approach an examine the significance for the children in their care." Therefore, then, pressure from without requires a redefinition of the mission of residential caring facilities and dictates that a different conceptual approach and treatment focus be considered.

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The pressure from within is on two levels. On one level is the external social–political–legal pressures which produce both staff frustration with the new guidelines and staff desire to better prepare children for return to families. The second level pressure has been a longstanding issue. It is the pressure to define the role and status of child care workers within the residential treatment program, so that the definitions are commensurate with their importance to the child's treatment.

This paper is an attempt to elucidate one agency's attempt to deal with the external and internal constraints facing all of us in residential work in a comprehensive, integrated and constructive manner. The agency implemented a developmental model for the milieu treatment of children and adolescents which utilizes a family approach to treatment. In this model, the child care worker is head of a small "residential family" of three children. She or he is also the person in charge of implementing and facilitating each child's treatment. What follows is an explication of this Primary Caretaker Model (PCTM) is designed for use in a residential facility.

The PCTM was developed for a children's inpatient psychiatric unit in 1974 by Humberto Nagera, M.D., a psychoanalyst who trained with Anna Freud at the Hampstead Clinic, London, England. It was first implemented with latency- aged children. This model was then adapted for use at The Children's Home, Inc., (CHI), a residential treatment center in Tampa, Florida, in July, 1984. CHI is a psycho–dynamically and developmentally orientated treatment program accommodating approximately sixty–eight children ages five to eighteen. The junior unit consists of three cottages of latency–aged children (5–12 year–olds) and the senior unit consists of three cottages of adolescents (13–18 year–olds). Each cottage houses twelve children. These children are extremely troubled and would look familiar to all professionals working with emotionally disturbed children in child care environments. They most often come from chaotic, neglectful, and abusive backgrounds. They bring to the program the emotional problems and developmental delays which result when a child is exposed to and raised in an unhealthy family environment. For the most part, our children are not retarded, severely delinquent, or actively psychotic.

CHI differs significantly from an inpatient psychiatric ward of a hospital and so the adaptation and implementation of the PCTM differs from Nagera's model. However, the basic concepts of the model remain the same. Working with children in surrogate family situations is not a new concept, but setting up separate family units within the cottages of a large residential program, we believe, is a significant departure from traditional residential care milieu models. The PCTM attempts to recreate, as closely as possible, a family situation for each child while he/she is in residential care.

This paper will address the rationale for the PCTM from the perspective of treatment for the child and from the perspective of the child care worker. Included in the discussion will be a description of the model's implementation at CHI, the associated problems and changes that are part of the implementation, and a summary of this process with recommendations for utilization at similar residential caring facilities.

Perspective of Treatment for the Child

Dr. Nagera's aims for implementing the PCTM were different from ours and are outlined in his book, *Developmental Approach to Child Psychopathology* (Nagera, 1981). Implementation of the model in our program was not prompted by any child caring problems we were experiencing in the milieu, but rather by treatment objectives for children which our program did not adequately address.

CHI provides treatment for children who have been unsuccessful in previous family and substitute family placements. Most of these youngsters have had multiple placements in foster homes, adoptive homes, and shelters or have been in and out of their own family homes. As stated in the introduction, the long- range goals for these children, particularly those thirteen years and younger, is return to a family placement (natural, adoptive, or foster). Among the children who are fourteen years and older, are a large group who do not have a family alternative and for whom the long-range plan is continued placement in our residential care program with eventual transition to independent living.

The length of stay of children five to thirteen years is at least one year, but our average length of stay is nineteen months. However, the average length of stay for the thirteen-to eighteen-year-old group is two years with some children staying as long as four years. Especially with the long-term stays of this latter group in mind, we begin to question how best to meet the needs of our children, young and old.

Working from the premise that a family is the natural and healthiest way to raise children, it became important to us to understand the impact of the institutional aspects (living in large groups and exposure to diverse psychopathology and multiple caretakers) on the child's development and progress in treatment of problems, but also for paying a part in the socialization and ongoing development of each child.

Our children's capacity for healthy object relations (Freud, 1965) is severely damaged due to their experience in chaotic, inconsistent, and multiple family settings. We have found, both in our setting and when we place them back in families, that these children are unable to trust adult caretakers, reciprocate with them, or handle the demands and intensity of family interactions. Recognizing this, we also began to question how we could overcome this problem within the limitations of our residential program given the size of our cottage population. Over the years, we had rationalized these program deficits as unavoidable, but once we accepted a

commitment in nurturing normal development as a key program responsibility, we became increasingly uncomfortable with such institutional restraints on treatment.

It was Dr. Nagera's first visit to our program in February, 1984, that precipitated our interest in the PCTM. The model seemed to have the potential to address some of the treatment dilemmas we were facing, as well as some of the "innate" negative aspects of life in a large residential treatment program. In June, 1984, we made the decision to implement the model in our junior unit. Eighteen months later, we added the model to our senior unit.

In addition to addressing the problem of preparing youngsters for return to family life, we have seen the PCTM meet the treatment goals of children with increased effectiveness. Specifically, the model provides the opportunity for identification with adult role-models, working through issues of sibling rivalry, preparation for independent living, and work with biological or foster families in a systematic and organized way.

Impact of the Model on Normal Growth and Development

"Normalizing" (Lippman, 1977) residential programs is not a new concept. It requires the institution to provide a program which affords the child an opportunity for life experiences that are congruent with experiences which all children encounter in normal development.

The PCTM provides the child and the child care staff with a system which is much more like the real world, even though the children are living in an institutional setting. Children typically grow within the structure of a family, relying on one or two primary adults to parent them. They usually have to share these parents with siblings or other family members. Through the experience of being part of a family they learn about fairness, cooperation and delayed gratification. Throughout history, civilized cultures have utilized a family environment to socialize their young and help them grow and develop.

Nagera (1981) describes the benefits of PCTM on a psychiatric ward in the following manner:

> ...the wards reproduce to a reasonable degree the structure and organization of a city at large. They are a sort of experimental model of it. More importantly, this structure offers an excellent opportunity to observe, study, handle, and teach the child adaptational and interactional skills that he may not have (p. 464).

This can also be true of the PCTM in a residential treatment setting. The PCTM allows the child special attention from an adult on a consistent basis. A great advantage of this model is its natural breakdown of large units into small groups. Activities are planned in terms of the structure of a "residential family" and not in terms of the cottage as a whole. The model minimizes the exposure of each child to the psychopathology of twelve other children

and the child care worker can focus his/her attention to the needs of three children instead of twelve. The child, in return, has one adult on whom they can depend during their stay in residential care. That adult functions as a parent to the child.

Capacity for Healthy Object Relations

This is an area of concern with children of all ages, but particularly with latency–aged children who are actively preparing for family placement. It is latency–aged children who are developmentally in the greatest need of a parent figure. At CHI we had a number of children who had been receiving treatment for one to three years and who continued to display extremely severe behavioral problems. While they had improved in many ways, we were concerned about their lack of significant attachments to any of their adult caretakers. In our experience such children do not successfully transition to life within a family.

Since the implementation of the model, we have seen significant improvement in children's ability to relate to parent figures, the primary caretakers (PCT). Children need one adult on whom they can depend, but often institutions encourage multiple, shallow relationships between children and staff. Because the primary caretaker is completely responsible for all aspects of the child's treatment plan, this model encourages attachments and relationships with a primary worker which children so desperately need but which institutional settings have been unable to provide.

Case example: "M", age 8, is a boy who had resided in our program for two years. Prior to placement he had been subjected to abuse and neglected by his mother and her various boyfriends. "M" had been in and out of his mother's home since he was two, being removed for neglect, placed in a foster care home, and then returned home. At three he was permanently placed in foster care. He had one foster home placement which failed. During this time he had the dubious distinction of being the first child expelled from the area's Head Start program. "M" was placed in our program at age 5 years, 11 months. During his two years of treatment at CHI his behavioral, emotional, and academic difficulties had improved, but were still significant.

After we implemented the PCTM, "M" was assigned a primary caretaker in the cottage where he lived. In the next year we saw dramatic improvement in "M." He became dependent on his primary caretaker and experienced increased difficulty on her off–days. Eventually, these problems decreased as their relationship strengthened. "M" played out his ambivalent feelings (love and anger) about mothering figures toward her in their relationship, something he had not done with her before she became his primary caretaker. We feel "M's" improvements were made possible through his relationship with his primary caretaker. The relationship allowed "M" an opportunity to work through conflicts about his mother by displacing these conflicts onto his primary caretaker. Since she had the skills

and training to understand "M's" behavior, she could help him. We see this pattern repeatedly with primary caretakers and their children.

It must be noted that as a clinical team, we were well aware that "M's" difficulty in forming relationships was not just a result of a deficit in our former program nor was his improvement in this area strictly a result of the PCTM. "M" had been receiving ongoing psychotherapy since admission to our program and progress was enhanced through his work in therapy. We do feel, however, that the PCTM provided a real world arena where these conflicts could be worked on daily with the support of psychotherapy. Our experience has been that psychotherapy by itself is not enough for children like "M." With "M", we saw significant and positive changes in his identification with adult role models and in his relationship to peers. The process of identification with a significant adult was enhanced and quickened through the use of the model. Also, treatment objectives such as incorporation of values, problem–solving techniques, improved social skills, behavioral control and verbalization of feelings were facilitated.

Typically, sibling rivalry is a major cause of disruption in family placements of our children. Issues of sibling rivalry become more discernible with the PCTM. The child's feelings of jealousy, competition and envy toward the other children in his residential family present an excellent opportunity to the child care worker and the child for working together to master and control these feelings.

Perspective of the Child Care Worker

As a child care worker, I can still remember the inevitable questions from family and friends, "When are you going to get a real job and utilize your degree?" "When are you going to stop babysitting those kids?" Those are questions with which many child care workers can identify and which frustrated and confused me. I always felt it was the toughest job I had ever held, so if it was not a "real job," I could not imagine what a "real job" would be like. I was utilizing every bit of my newly acquired B.S. degree and found that it was not enough. But, I was also experiencing great satisfaction with my work. I had the opportunity to interact with children on a daily basis. I had a chance to help them change. This seemed to be a very important job and much more than babysitting.

During fifteen years of work in residential care, I have struggled with the role and status of the child care worker. In many residential care programs, the child care worker takes a backseat to therapists, supervisory staff, or administrative staff. Yet, when we ask those involved in the field which staff member is the most essential to a child's treatment, they inevitably answer, "the child care worker." Likewise, when you ask society in general who is the most important person in a child's development, they answer, "the parent." In reality, the importance of parenting does not receive sufficient recognition in our society, nor does the role of the child care worker in residential treatment programs. It seems as if child care

workers must assume other roles beside that of parent substitute before their role is recognized as important.

In today's society, negotiating parenthood with normal children is an awesome task requiring much skill and knowledge. To parent the children who come into residential treatment, the task is even greater and requires extensive training. A child care worker should be trained in growth and development, child psychopathology, behavior modification, values clarification, psychopharmacology and learning problems. The role of the child care worker is, indeed, complex, difficult, and critically important.

At CHI, we believe that the milieu work of the child care staff operates hand-in-hand with the clinical work of the psychotherapist and family therapist. The roles of each are specific.

The child care worker deals with external problems which prevent the child from successfully adjusting in a family situation.

The psychotherapist works with the internal or psychic conflicts that interfere with a child's developmental process and successful family adjustment. Psychotherapy with children in residential treatment is another area of discussion and a subject for another paper. This writer takes issue with those programs which promote the child care worker as a psychotherapist in the milieu. The psychotherapist should not be the central figure in the child's milieu treatment planning or implementation (Whittaker, 1979), nor should the child care worker be a psychotherapist. It is also our experience that many more children are capable of utilizing insight-oriented psychotherapy than the literature indicates.

The family therapist works on the problems within the family system which contribute to the child's removal from the home and which keep the child from returning home.

Each of these three roles takes specific training and skills. However, the effectiveness of the two therapists is dependent on the quality of the milieu treatment delivered by the child care worker.

The PCTM functions with the child care worker being the central figure in the child's treatment. This is consistent with the child care worker's role. Emotionally disturbed children in residential care receive most of their treatment within the milieu. This statement in no way infers that psychotherapy is less important. The process of psychotherapy with the child in residential care is made possible when the milieu is stable, structures, and nurturing as is the care for psychotherapy in an outpatient setting. The process is hindered when the milieu is not therapeutic.

Utilizing the PCTM, in our opinion, not only says to the child care worker, "What you do is important", but it puts these words into action. It also recognizes parenting as the important job that it is. You do not have to be a therapist to be significant in the child's treatment. Child care workers are not psychotherapists, but they are trained to be milieu therapists. The milieu therapist functions in the role of parental figure with specialized training. The role of the psychotherapist is carried out by someone else. After all, parents cannot do psychotherapy with the children!

Throughout the years, the treatment role of the child care worker has become separated from the more formalized role of the individual and family therapist. The latter is often given more prominence because individual and family therapists are highly trained. Child care workers traditionally are not. This is where, I believe, the separation has occurred. You cannot, however, be a PCT with emotionally disturbed children and effectively provide treatment to them without specific and intense training.

Small and Carman (1986) surveyed child care workers in an extensive study to determine what job tasks child care workers most frequently performed, what they viewed as most important, and what tasks they performed with most skill. The tasks of the child care workers were divided into the following six areas: general professional skills, policy, primary care, behavior management, team/staff communication, and organization/planning.

Results of this study suggest that child care workers perform the tasks of primary care (defined as physical, social, emotional and nurturance) with the greatest frequency and consider these most important. Tasks of behavior management rated second. General professional skills (defined as the child care worker's role as a teacher and therapist) ranked third in importance yet were performed infrequently and with the least skill. It is the lack of these skills which has lowered the status and role of the child case worker. Small and Carmen (1986) listed twenty-four tasks under general professional skills which are pertinent. Nineteen of these job tasks are job responsibilities of the PCT in our program.

In our opinion, the above findings support out contention that the role and status of the child care worker can only be improved when they (a) are responsible for a major portion of the child's treatment and (b) receive the training and opportunity to develop the skills commensurate with those responsibilities. The child care workers in the survey reported above also stated that along with behavior management, primary care is the most important task for all parents and should not be separated as nonprofessional tasks of the child care worker (Maier, 1979). The skill needed to carry out such tasks with emotionally disturbed children does not come from a B.A. degree, living in one's family, or being a parent of children, although all of these are potentially useful. The skills needed by the child care worker come from formal training and experience with the specific problems and unique differences associated with parenting emotionally troubled children.

From an administrative perspective, the agency must encourage all personnel to funnel their input concerning the child's treatment through the PCT. Decisions, suggestions, and changes in the child's plan must be made in consultation with the PCT. Agencies utilizing the PCTM will find that administrative changes are necessary in order for the model to work effectively.

Implementation of Model

When we began utilizing the PCTM, we asked child care workers to give us a one-year commitment. However, since our average length of stay per child is eighteen months, we now realize that a two-year commitment is critical to the success of the model. A two-year commitment makes it possible for most children to have the same PCT during placement.

A critical objective for all agencies with child care programs is to reduce the turnover rate of child care staff as this adversely impacts on the care children receive. At CHI, we have begun to see a decline in our turnover rate as we implemented the following administrative policy changes: higher salary ranges, provision for financial assistance toward bachelor and masters level education, and creation of a career ladder for child care workers.

It is our belief that implementing the PCTM further contributes to a decrease in turnover. This is because of an increased feeling of responsibility and voice in the child's treatment (i.e., ownership) and a growing sense that to leave means more than changing jobs; it means leaving your family.

Our agency asks of the child care workers who need to leave that they do so after they have fulfilled their two-year commitment and with ample notice (at least three months). As long as there is enough notice, the child and the PCT have an opportunity to work through the process of separation in a therapeutic manner.

After a child care worker makes the commitment, he/she is assigned three children who comprise the PCTM family (residential family). In our program, it is the PCT who is responsible for implementation of the child's treatment plan. PCTs are not required to "do" all the treatment the child needs, but they insure that all aspects of the treatment are being accomplished. The following is an outline of PCT job responsibilities at CHI:

1. Milieu

A. Each cottage has its own rules and routines which the PCT explains to his/her children. Behavioral charts are done on an individual basis. The PCT identifies target behaviors and sets up a program with each child. The PCT utilizes the other treatment team members when developing this program.

B. Daily routines include wake-ups, meals, bedtimes, hygiene, chores, recreation time, study time, medication (if applicable), privileges, and restrictions. All of the above are monitored by the PCT on a daily basis. If the PCT is off duty at any time, it is his/her responsibility to acquire, from the alternate worker, all information regarding the child's adjustments while he/she are gone.

C. Crisis and life space interviewing are the responsibility of the PCT.

2. Psychotherapy

The PCT works with a psychotherapist as would a parent. PCTs are responsible for getting the child to the sessions, communicating with the therapist, and utilizing the therapist as a consultant regarding the child's overall treatment plan.

3. Family Therapy
The child care worker's role working with families has expanded with this model because residential programs are being required to expand the treatment services they deliver to families (Whittaker, 1979). The PCT works with the family therapist to meet the needs of the family. The PCT or designated alternate meets with the family in the cottage before and/or after home visits. This provides assistance to the parents on how to better parent their child by utilizing both role-modeling and discussion (Littauer, 1980). Because the children are in a practice family while in residence, it is important that the PCT and the parents establish a comfortable relationship and role. Parents can easily feel threatened by the PCT's role in their child's life and perceive the PCT as a competitor. Thus, the PCT must reassure and support the parents, in a cooperative manner, conveying to the parents that both sets of parents have the best interest of the child in mind.

4. School
Our goal is for parents to view and utilize the PCT as a support person and teacher. The PCT's school responsibilities model that of any good parent with a child in school. They monitor the child's academic work and progress. The PCT attends all staffing and parent teacher conferences and the PCT consults with school personnel regarding the establishment of study time programs within the cottage for remediation of academic deficits.

5. Community
The PCT monitors the child's involvement in the community. Participation in community sports and recreation programs are initiated by the PCT. For adolescents, this also includes off- campus employment. Our children will eventually return to the community, so there must be a strong program emphasis on being part of the community. The PCT is responsible for involving each child in the community at a level appropriate to that child's functioning.

6. Documentation and Logging
Daily logging of the events and behaviors of each child in his/her family is the responsibility of the PCT. This logging is coordinated with the alternate worker. Behavioral observation charts are, at times, utilized for medication monitoring and specific treatment planning.

7. Scheduling
As with Dr. Nagera's original model, the PCTs are scheduled when the children are in the cottage - after school and on the weekends. On the PCT's off days, an alternate worker is assigned to the PCT's family.

8. Communications
The development of a clear communication system is crucial to the PCTM. The PCT has to insure that all co–workers in the cottage are aware of the treatment plans for each child in his/her family. Since the primary caretakers work shifts, they must communicate on a daily basis with the alternate worker. At CHI we utilize daily logs for each child in each family and family logs with three children per log.

9. Other
Other PCT responsibilities include medical and dental appointments (coordinated with the nurse), inventory and purchasing of clothing and spiritual life involvement consistent with the wishes of the natural family.

Training

There is extensive literature in the field about training and professionalizing child care workers. We, too, believe in training and have developed a twelve week training program for all child care staff beginning with the first week of employment. The following is a list of the twelve–training topics covered:

1. Philosophy and Overview of the PCTM
2. Structure and Its Use
3. Therapeutic Use of Routines
4. Parenting Plus
   a. looking at self;
   b. role–modeling;
   c. teaching skills, values, and perceptions
5. Looking at Discipline
6. Developing Therapeutic Relationships
7. Teaching Children Self Control
8. Group Dynamics
9. Basic Growth and Development
10. Working with Families in the Cottage
11. Communication
12. The Crises Intervention

These topics are covered as an overview and primer for the worker. Ongoing in–service training continues for the child care worker with bi–monthly sessions. Since the implementation of the model, our training also includes monthly training sessions with the PCT which cover particular topics (e.g., working with families). Our training program still needs additional work and we are currently in the process of reorganizing our training to meet the increased needs of child care workers functioning within the PCTM.

General Comments

The PCTM has considerable impact on the administration of a residential treatment program. It calls for decentralization of responsibility for the child's treatment from administrative, supervisory, and clinical staff to the primary level: the child care worker. This decentralization allows individualized child treatment, but demands great efforts toward better communication and monitoring on the part of the Agency. All staff involved in the child's treatment must direct questions, input and communication to the PCT. The PCT must make decisions regarding the child's treatment in consultation with the treatment team and no member of the treatment team can make decisions without consulting with the PCT. Administratively, this means that meetings to discuss issues involved in treatment implementation must be held on a weekly basis. Implementation of this model also means that cottage supervisors must drastically alter their role, particularly in regard to decision-making in each child's treatment.

Prior to the implementation of this model, children saw the cottage supervisor as the decision-making person within the cottage. The PCT is now seen in that role by the child. In this model, cottage supervisors are required to be more active in the training and support of the PCT and alternate. Their role is to evaluate, provide feedback, and serve as a resource to all PCTs and alternates within their particular cottage.

Summary

The purpose of this paper has been to present a milieu treatment model which adds a family perspective to the treatment of children in residential care while also professionalizing and strengthening the critical role of the child care worker. This model is extremely helpful in a large residential program because it allows individualization of each child's treatment program and emphasizes return to a family or community environment.

The PCTM works particularly well with those residential programs providing psychotherapy and family therapy. The model recognizes the particular skills and role of both the therapists and PCTs while also encouraging the close working relationship essential for effective residential treatment.

There are issues pertinent to the effectiveness of the model which could not be sufficiently addressed in this paper. These issues include working with families, working with latency-age children versus adolescents, communication guidelines, scheduling and the role of psychotherapy. These need further exploration.

Whittaker (1979) stated three guidelines for service planning in residential care. They are: the establishment of a "set of linkages" between the program and the major systems of the child (family, peer group, school, church, and community); the program should utilize the family in the child's treatment; the program focus must be on the growth and development of the child's "total life sphere." It is our opinion that the PCTM enables a residential program to meet these guidelines and provide comprehensive and effective residential treatment to children and their families.

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A CHILD FIRST

Anthony Frazier

The handicapped person who doesn't ask for help,was a child first

The dependent individual who has been abused by those he trusted, was a child first

The delinquent youth who runs away and steals, and refuses to let anyone get close, was a child first

The troublemaker who is unwilling to make commitments and achieve goals, was a child first

The sex offender who has learned and used power to overcome others, was a child first

The "foster placement" who struggles with friendships and holds little hope, was a child first

THE CHILD CARE WORKER WHO IS ABLE TO SEE PAST THE LABELS, ALWAYS SEES A CHILD FIRST