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Residential Treatment of Adolescents

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RESIDENTIAL TREATMENT OF ADOLESCENTS

Residential, inpatient, or hospital treatment refers to a comprehensive therapeutic process addressed to the adolescent whose psychopathology is of a degree that warrants his removal from his usual familial and social environments, with subsequent admission into full-time institutional care. Such treatment is reserved for those adolescents who have been unable to harness or channel their instinctual energies and hence have failed at utilizing peer and adult relationships to sustain psychosocial growth. For such adolescents, residential treatment must provide two basic therapeutic ingredients. (1) It must provide accurate diagnosis, sensitive understanding, and adequate psychiatric treatment of the adolescent's illness. (2) It must provide cognitive-intellectual and emotional growth experiences, including education, and occupational, recreational, and vocational modalities appropriate for the patient's age and cognitive development and for the nature, degree, and chronicity of his illness. These two ingredients are, as it were, so intimately interrelated as to preclude application of the term "residential treatment" to any purportedly therapeutic inpatient program essentially devoid of either. Thus, whereas the healthy adolescent pursues age-appropriate growth experiences per se and the adolescent in outpatient treatment pursues them along with his therapeutic process, the inpatient adolescent receives them as a carefully prescribed, integral part of his residential therapeutic experience, and the residential setting must be staffed

to provide them.

As employed here, the term “residential treatment” has reference to a complex, fulltime inpatient process provided within a service, setting, or unit specialized for and adapted to the needs of patients in the early and middle periods of adolescence (ages twelve through seventeen years), and not to services or wards that attempt concomitantly to provide treatment for a mixed population of adolescent and adult psychiatric patients. Although controversy continues regarding the advisability of treating adolescents on adult mental hospital wards, there is growing awareness that optimal care, which implies intensive, reconstructive treatment conducive to lasting, healthy personality change, is best carried out amid the adolescent peer group by professional staff, specially trained in techniques most appropriate for the adolescent, who serve as healthy identificatory models for him. Finally, granting that childhood psychopathology develops from, and in turn gives expression to, pathological familial relationships, adequate residential treatment must include the means conducive to therapeutic modification of such relationships, including intensive parallel or concomitant casework treatment, family therapy, and, in some cases, individual psychotherapy or psychoanalysis for parents.

Developmental and Diagnostic Considerations

Irrespective of presenting symptomatology, the adolescent who is a candidate for residential treatment is invariably found to have failed at the interrelated developmental tasks of separation-individuation and emancipation. The more precise extent of that failure depends on whether his difficulties arose prior to or after the inception of the mother-infant symbiosis during the first postnatal year of life. Following the formulations of Kanner and of Mahler in the case of infants and younger children, it is possible to divide the great majority of adolescent inpatients into two major etiologic-diagnostic groups.

Group 1. Pre-symbiotic Adolescents

Adolescents diagnosed as pre-symbiotic (autistic-pre-symbiotic) are traditionally viewed as suffering from nuclear, or process, schizophrenia. Their pervasive psychopathology has been present since early infancy; they are severely disorganized, show perceptual-sensory, cognitive, affective, and expressive-motoric dys-synchronies and often display the "soft" neurological signs found in schizophrenic children, whom Bender has termed "pseudo-defective." The term "pre-symbiotic" applies to them from recognition of their failure to have achieved a satisfying relationship with a mothering figure, hence to have received the protection of the maternal stimulus barrier during the period of maximal vulnerability of the infantile ego. As a consequence, there remain profound, chronic defects of the ego boundaries, with

persistence of introjective-projective defenses and reliance upon magic-hallucination, somatization, and denial. The term “autistic” applies because these adolescents live amid an inner world replete with a welter of mixed ideal and horrific bad internal objects, which are fused with endopsychic sensations and images, and hence with their primitive perceptual notions of their bodily processes, organs, and products. As a result, meaningful relations with others are impossible, and the prospect of closeness or intimacy is likely to provoke inordinate clinging, withdrawal, or attack. These adolescents are admitted to the hospital with long histories of developmental lags and of psychosocial and educational failure; many are stigmatized as brain-injured or retarded. The overwhelming majority receive postadmission WISC full-scale IQs in the borderline retarded range or below. A variety of diagnostic labels are regularly accorded the pre-symbiotic adolescent. (See Table 24-1.)

Group 2. Symbiotic (Borderline) Adolescents

Adolescent inpatients classifiable under this rubric have indeed experienced the elements of a need-satisfying mother-infant object tie; their psychopathology reflects their failure to have separated from it, and hence to have undergone any significant degree of individuation. Some of these adolescents are overtly, even floridly, psychotic, while others present their psychopathology in the form of hyperactive, impulsive, megalomanic, asocial, or antisocial (pseudopsychopathic) behavior, or else by means of a wide

spectrum of anxiety-laden, obsessive-compulsive, phobic, and hysteriform symptomatology (pseudoneurosis). Irrespective of specific symptoms, careful study discloses heavy reliance upon an autistically organized inner world, the content of which centers upon mother-child fusion and reunion fantasies, which must at all costs be protected from the scrutiny of others.

Table 24-1

AUTHOR'S TERMINOLOGY	EQUIVALENT DIAGNOSES	OFTEN MISDIAGNOSED
Pre-symbiotic psychosis of adolescence	Nuclear schizophrenia	Mental retardation, moderate to severe
	Process schizophrenia	Psychosis with:
	Childhood schizophrenia pseudo-defective type	Mental retardation
	Childhood schizophrenia, (organic group)	Organic cerebral impairment
	Schizophrenia, childhood type	Chronic brain syndrome, due to various causes
	Schizophrenia, catatonic type (occasional)	Various syndromes of ego and developmental arrest
	Schizophrenia, hebephrenic type (occasional)	
	Kanner's syndrome: infantile autism (rare)	
	"Atypicality"	

Within this group are found some adolescents labeled as "brilliant but

crazy," including the odd or strange "model student" and occasional examples of the "childhood genius," whose purported genius reflects massive pseudointellectual overcompensation rather than genuine originality or creativity. Just as the pre-symbiotic adolescent is often misdiagnosed as feebleminded, mentally retarded, or brain-damaged, so is the symbiotic adolescent frequently misdiagnosed as psychoneurotic, characterologically disordered, or else suffering from some sort of phase-specific adjustment reaction or turmoil state supposedly specific for adolescents. The postadmission WISC full-scale IQs of symbiotic adolescent inpatients range from borderline through superior scores. Some are indeed intellectually gifted but have achieved below their educational potential as a consequence of the inroads of their illness, while others have achieved brilliantly in academic work at the expense of otherwise healthy peer-group and wider social and interpersonal relations. Sudden or insidious decompensation occurs in these adolescents, as it often does in younger symbiotic primary school children, when the requirements of the school and the wider social environment threaten to overwhelm the youngster's precarious, guarded autistic personality organization. Table 24-2 records some of the numerous diagnostic labels regularly assigned to the symbiotic adolescent.

Historical and examinational findings regularly demonstrate the following characteristics of the adolescent who is a candidate for intensive residential treatment.

1. Major signs of ego weakness, including substantial reliance on such primitive defenses as projection, introjection, regression, and denial; impairment of the synthetic function of the ego, with ensuing disruption of self-environment relations and decomposition of perceptual, cognitive, affective, and motor functions; predominance of anxiety of the instinctual type with associated failure of normal repression; impairment of object relations; serious impairment, or lack of, basic trust; persistence of primary-process (autistic; dereistic) thinking, with reliance on transitivism and gestural and word magic; persistent infantile grandiosity and serious difficulties with self- and sexual identities.

Table 24-2.

AUTHOR'S TERMINOLOGY	EQUIVALENT DIAGNOSES	OFTEN MISDIAGNOSED
Symbiotic psychosis of adolescence	Borderline syndrome of adolescence	Adjustment reaction of adolescence
	Reactive schizophrenia	Adolescent turmoil
	Childhood schizophrenia, pseudo-neurotic type pseudopsychopathic type	Psychoneurosis (anxiety, phobic, hysterical, depressive, obsessive-compulsive, "mixed," and so on)
	Schizophrenia, childhood type	Various schizophreniform conditions
	Schizophrenia, chronic undifferentiated type	Personality disorder, especially delinquent, antisocial, schizoid, and the like
	Schizophrenia, catatonic type (occasional)	School phobia (rare)

Schizophrenia, hebephrenic type (occasional)	Various syndromes of ego and developmental arrest

2. Major problems with instinctual drives, including burgeoning or extreme failure of inner controls, leading to profuse if fluctuant acting out, confusion, and turmoil; and schizoid patterns indicative of massive ego constriction, leading to withdrawal and alienation.

3. Failure of interpersonal relations, including inability to utilize intrafamilial and wider social and peer relationships in the service of self-control and self-direction.

4. Inability effectively to utilize proffered environmental supports for ego functioning, including those of the family and the wider cultural environment, particularly the school.

5. Presence of latent or overt classical thought disorder, which conveys failure to have achieved a significant measure of abstract categorical (operational) thinking by early adolescence. (When viewed against a background of sudden, progressive, or chronic psychosocial distress, the presence of classical thought disorder may be considered pathognomonic for the adolescent who requires intensive residential treatment.)

Diagnosis of the Family

Irrespective of social class, the family of the adolescent inpatient will almost invariably be discovered to have raised and dealt with him as if he were something or someone other than who he in fact is; that is, to have a-personated or depersonified him. A consequence of parental psychopathology, such de-personification operates according to a general pattern, which Johnson and Szurek first described in the case of the delinquent or antisocial child and adult, and severely inhibits and distorts identity formation.

Detailed study of the families of adolescent inpatients discloses their similarity to the pervasively disturbed families described by Bateson, Lidz, and Wynne, the relationships within which have been subsumed under the term "amorphous family nexus." Such families are organized essentially along autistic lines, with such features as the pervasive use of double-bind communications; blurring of age, generational, and sexual roles; shifting and fluid individual identities; patterns of irrational thinking with distorted perception of the extrafamilial world; inadequately con-trolled or pathologically over-controlled instinctual urges, and diffusion and obfuscation of leadership and authority. The adolescent's psychopathology thus represents, in sum, his prior internalization of these pathogenic patterns, his immense ambivalence toward them, his inability to communicate about them, the secondary gain of his efforts to comply with them, and his miscarried efforts to break free of them.

The Residential Milieu: General Considerations

The genuinely therapeutic residential milieu is neither a school, foster care home, detention facility, recreational center, nor correctional institution, although at various times it functions in all these roles. Rather, it comprises a small psychiatric hospital, the staff of which represents a group of competent professionals, each with a well-defined role, whose main tasks include the detection, control, clarification, and interpretation of the patient's symptomatic behavior. The setting should be reasonably self-contained, with an ongoing in-service training program for its staff, in order to limit or eliminate the classical clinical-administrative dichotomies that seriously complicate and often vitiate the performance and goals of intensive treatment.

The fundamental, general functions of the residential milieu for the seriously ill adolescent include:

1. Removal of the patient from the pathogenic family nexus and from the extra-familial environment, the demands and expectations of which have overwhelmed him.

2. Shelter and protection, including interpersonal, pharmacological, and physical devices to graduate and limit incident stimulation, hence to offer protection against ego trauma.

3. Appropriate, consistent (hence predictable) external controls, the

purpose of which is to transduce communications inherent in symptomatic verbal and nonverbal behavior into secondary-process language.

4. Opportunities for controlled therapeutic regression, with emergence of transference responses, which in turn reveal the spectrum of the adolescent's particular, overdetermined coping mechanisms, including those that represent his resistances to treatment.

5. Recognition and diagnosis of the manifold of pathogenic, de-personifying communications and role and identity confusions characteristic of the patient's family nexus.

6. Appropriate, intensive use of the techniques of confrontation, clarification and interpretation vis-a-vis the patient and his parental surrogates, in order to expose and alter their a-personative patterns of communication.

7. Promotion of the adolescent's need to identify with the residential staff as good objects, with concomitant emergence of his endopsychic nucleus of bad (internal) objects.

8. Provision of such ego-supportive modalities as ongoing education (residential school), recreational and occupational therapies, and, for some older adolescent inpatients, vocational training as part of their overall treatment.

The Resistance Phase of Residential Treatment

Irrespective of the route by which the adolescent and his parents have entered the combined residential treatment process, and whether voluntary or otherwise, they quickly develop a variety of resistances to it.® These resistances, whether gross or subtle, intense or fleeting, serve to disguise and protect the pathogenic family nexus, the congeries of wishes, needs, fantasies, and role distortions which all parties to the nexus share in common, including the secondary gains subserved by the family members', especially the patient's, symptoms. In the case of the pre-symbiotic adolescent, the resistances, often herculean, serve to ward off staff members' access to the enormously primitive inner world of part-object representations, exposure or loss of which the adolescent perceives as a threat to his very existence. In the case of the symbiotic adolescent, the need is to draw attention from the welter of primitive refusion and reunion fantasies that comprise the matrix of his psychopathology. In the case of the parents, the resistances aim toward deflecting the family therapist's or the caseworker's attention from the various de-personifying themes characteristic of the parent-child relationship as well as to deny or assuage the guilt associated with them.

Resistance behavior conveys the adolescent's particular spectrum of archaic, overdetermined coping devices, particularly in relation to authority or surrogate figures from the past. Its recognition, clarification, and interpretation are best carried out in a closed ward or cottage, where comprehensive external controls and carefully titrated privileges serve to

bring the adolescent into engagement with, and prevent his avoidance or evasion of, staff members.

The most important forms of resistance behavior that adolescent inpatients regularly demonstrate are the following:

1. Identification with the aggressor, including some forms of early positive transference, and imitation or mimicry of adult staff members in a counterphobic effort to ward them off.

2. Leveling, which represents the adolescent's effort to de-personify staff members into peer or sibling figures.

3. Flirtatiousness and seductiveness, which convey efforts to sexualize relationships with staff figures, thereby to deflect their attention from other actions, fantasies, preoccupations, and sensory-perceptual experiences.

4. Over-submissiveness, which has obvious counterphobic intent.

5. Scape-goatism, either active, by which the adolescent sets up a ward-mate or motivates him toward proxy acting out, or passive, exemplified by the adolescent who masochistically collects injustices or actually sets himself up to be assaulted or punished by peers or staff members.

6. Outright rebelliousness, ambivalently aimed at warding off staff members through provocative or wildly disruptive behavior as well as provoking patient-staff contact through

application of necessary physical restraints or controls.

7. Transference diffusion (also termed "transference splitting," a notable form of which is often called "manipulation"), including gossiping and tale-carrying and various efforts to "split" staff members or even whole shifts of aides or child-care workers, thereby to conceal thoughts, feelings, and other subjective experiences behind the ensuing confusion.

8. Persistent avoidance, including classical negativism, apathy, somnolence, daydreaming, various seizure and dissociative phenomena, refusal to eat, and efforts to provoke restriction and isolation.

9. Somatization, by which physical complaints become the metaphorical vehicle for body language communications as well as a means of deflecting staff attention from thoughts, feelings, fantasies, and delusional preoccupations.

10. Peer-age caricaturing, also termed "out-typifying one's self," by which the adolescent attempts to deny or ward off attention to disturbing subjective experiences through actions that appear as slight exaggerations of behavior traditionally viewed as "typical of teenagers."

11. Clique formation, in which peer- or small-group interactions are used to preclude engagement with staff members.

12. "Craziness" and "pseudo-stupidity," the aim of which is to arrest or paralyze staff attention to disturbing inner experiences, whence the message "I am too crazy (stupid) to bother

about, so why don't you leave me alone (or let me out of here)."

13. "Intellectual" pursuits, including literary, graphic artistic, and scientific pursuits and projects, which have basically autistic significance, notably if indulged in without careful staff supervision.

14. Elopement or running away, a complex, overdetermined act in response to a variety of aggressive, erotic, reunion, and rescue fantasies. Although running away may and often does have positive therapeutic meaning, its occurrence during the resistance phase of treatment almost always betokens an anxious need to preclude therapeutic engagement.

Analysis of the adolescent inpatient's resistance behavior and metaphors requires the staff's sustained and comprehensive attention to every nuance of his daily actions and interpersonal relationships. Concomitantly, the parents (or, in some cases, other surrogate figures) bring to the caseworker or the family therapist resistance communications which in turn reflect their own anxiety, guilt, and patterns of de-personifying their child. These last comprise the following general categories:

1. The child as "thing," inanimate object or externalized part of one's self, a narcissistic part object lacking an identity of its own apart from that of the parent. (This category of de-personification is found amongst seriously disorganized, i.e., psychotic, parents.)

2. The child as parent figure, which reflects the classical parent-child reversal of roles.

3. The child as spouse, which reflects serious age and generational conflicts, with notably incestuous overtones and actions.

4. The child as sibling, in which the parent lives out with the child earlier sibling rivalries and conflicts derived from the inability to have separated from symbiotic ties with his or her own parents (i.e., the child's grandparents) .

5. The child as lifelong infant, reflective of the parent's own unresolved infantile needs and anxiety over assumption of genuinely adult goals and values.

In symbiotic cases, the adolescent's and the parents' resistances serve to protect, as it were, the parent-child tie, separation or emancipation from which evokes fresh charges of anxiety and guilt in both, which lead in turn to further regressive efforts at mutual clinging. Successful working through of the separation requires rigid control of parent-child contacts and correspondence; when accomplished, it signifies beginning resolution of the so-called loyalty problem, such that the parent in effect bids the child to trust and begin to identify with the staff members, and the child proceeds so to act. Even within an intensive, interpretive, carefully supervised residential milieu, such resolution ordinarily requires from twelve to eighteen months of concentrated work by all concerned.

In pre-symbiotic cases, the problem is more difficult and the outcome of the resistance work more problematic. Often, there are no available parents whom the adolescent can begin to objectify and from whom he might separate; hence the resistance work must center on the enormously difficult task of separating him, as it were, from the welter of magic-hallucinatory, mixed idealized, and terrifying internal objects amidst which he lives. Although no time limits can be assigned this process, some adolescents in this situation have managed to accomplish the resistance work within a five-year period of intensive residential treatment.

In both symbiotic and pre-symbiotic cases, successful completion of the work of the resistance phase of residential treatment betokens the inception of the adolescent's significant and enduring identifications with, the staff members, and of the parents' identification with and acceptance of their child's treatment, personified in the family therapist or the caseworker. The stage is now set for the beginning of the next, or definitive, phase of residential treatment, the hallmarks of which are (1) accelerating emergence of the adolescent's heretofore suppressed autistic preoccupations and coping efforts and (2) progressive clarification and amelioration of the family's pathogenic nexus of mutual de-personifications.

The Definitive Phase of Residential Treatment

Entrance into the definitive phase of residential treatment initiates what often proves to be a period of regressive storm and stress for the severely ill adolescent. It means giving up the core of bad introjects central to his psychopathology, the efflorescence of anxiety and guilt, which his symptoms have in part held from conscious awareness, emergence of the last vestiges of the powerful infantile-megalomania common to unseparated personalities devoid of basic trust, and the onset of various degrees of regression in all areas of psychological function. The whole process signals the ultimate failure of the adolescent's traditional splitting defenses and confronts him with the anxiety and guilt that attend the inception of whole-object relations. Thus, the adolescent proceeds to grieve or mourn the loss of his introjects, however pathogenic they may have been, with emergence of the exceedingly painful "mixed," or "impure," depression of childhood. During this period, he begins to speak of how "bad," "evil," and "destructive" he has been, and by his regressive experiences and actions mounts an eleventh-hour plea to the staff to remit the therapeutic pressure on him, to desist from further efforts to empty him of his objects, as it were. The staff understandably find it difficult to continue, as their powerful countertransference to the adolescent's experience of impending annihilation motivates them to restore him to his former state. Of signal importance in sustaining this introject work are the identifications with the staff the adolescent has developed toward the end of the prior resistance phase of treatment.

Of particular impact on the adolescent during this phase of his treatment is the failure of the secondary gain of his illness, a result that ensues in part from his parents' ongoing work in the family therapy or concomitant casework process, such that they begin to signal to him that they no longer need to de-personify him. Thus, he becomes doubly bereft as he perceives the departure of his bad introjects as well as his parents' failure to continue reinforcing his symptomatology. If he traverses this period successfully, the adolescent will have begun to objectify himself and his parents, hence to have given up his infantile ties to them.

The Resolution Phase of Residential Treatment[1]

Completion of the definitive phase of residential treatment ordinarily requires another year of intensive therapeutic work. As it begins to draw to a close, the adolescent becomes prepared for increased and unsupervised visits and passes with his family, and for the assumption of ever-wider responsibility for his own actions. His earlier identifications with the staff have supplied him with the nucleus of "good" introjects, which he had long lacked, and his increasing capacity to objectify himself and his parents now serves to preclude re-immersion in whatever remnants of the family's original de-personifying nexus of communications may persist. By now he has successfully worked through the paradigmatic 'loss" of his original, archaic, pathogenic internal objects, which will have strengthened him for the

mourning he must now perform as he begins to separate from the residential staff and milieu that have become so important to him. The latter will require several months of combined interpretive and supportive therapeutic work, accompanied by concomitant working through by the family as they prepare to "reacquire" their child.

The Basic Goals of Residential Treatment

For the pre-symbiotic adolescent, the full residential setting provides a highly concrete, compulsively styled, maximally predictable environment, as free as possible from peer-competitive experiences, and organized to support the one-to-one, or individual, therapeutic process, which is essential for the treatment of the nuclear schizophrenic adolescent. The individual therapist may be a psychotherapist, psychoanalyst, specially skilled residential teacher, or occupational or recreational therapist whose work with the patient inter-digitates closely with that of the other residential staff members and who receives intensive individual or group-process supervision to promote recognition and resolution of the enormously difficult countertransference problems that such work entails. The goal of the individual therapeutic process comprises catalysis for the crystallization of basic ego nuclei and points toward establishment of the patient-therapist symbiosis symbolic for the earlier mother-infant symbiosis, which the adolescent had never achieved. Once established, the patient-therapist symbiosis requires extended

efforts directed toward eventual de-symbiotization, which signals the adolescent's first real efforts toward separation-individuation. The whole process may be diagrammed as in Figure 24-1. In the case of the pre-symbiotic adolescent, establishment and beginning resolution of the patient-therapist symbiosis occur during the resistance phase of treatment. During that period, the patient comes to develop and work through the transference psychosis, symbolic of the enormously primitive and archaic experiences resulting from early object loss. Among the various factors contributory to the exceptional difficulty of this work, three emerge with particular clarity. (1) The patient's early resistances assume herculean proportions. (2) Staff countertransference of similar proportions emerges exceedingly rapidly. (3) Many such adolescents are products of thoroughly disorganized, fragmented pseudo-families, or else have long since lost contact with parents and other family members; as a result, there is often little, if anything, in the way of family therapy or concomitant casework treatment, and the resistance phase of treatment becomes prolonged.

FIGURE 24–1.

Resistance Phase of Treatment	*Definitive Phase of Treatment*	*Resolution Phase of Treatment*
Establishment of Symbiosis ↓ Beginning Resolution of Symbiosis	→ Continued Resolution of Symbiosis	→ Desymbiotization and Separation

For the symbiotic adolescent, essentially locked within a prolonged,

unresolved mother-infant fusion tie, the therapeutic goal comprises de-symbiotization with attendant separation and individuation. To this end, the major focus of the work of the resistance phase of treatment becomes the recognition and interpretation of the adolescent's fantasies, which center on megalomanic control of and reunion with family members, particularly the mother. As these recognitions and interpretations proceed, the residential program increasingly emphasizes progressive socialization, graduated expansion of privileges, peer-competitive participation (including residential school and occupational and recreational therapy classes), and increased personal responsibility. Although individual psychotherapy may be prescribed and is often helpful, it is not considered essential for the symbiotic adolescent, who often works best with a skilled residential psychiatrist directly in the ward or cottage area on a day-to-day basis. In particular, willy-nilly prescription of individual psychotherapy is contraindicated, especially during the resistance phase of treatment, lest the adolescent proceed to incorporate it into his splitting defenses, thereby vitiating its impact upon him. The process may be diagrammed as in Figure 24-2.

FIGURE 24–2.

Resistance Phase of Treatment	*Definitive Phase of Treatment*	*Resolution Phase of Treatment*
Recognition and Exposure of Symbiosis ↓ Beginning Resolution of Symbiosis	→ Continued Resolution of Symbiosis	→ Desymbiotization and Separation

Clinical-Administrative Structure of the Residential Service

Effective intensive residential psychiatric treatment represents the opposite of the pathogenic familial-social nexus, within which the adolescent's psychopathology has developed and to which it gives expression. This treatment includes establishment and maintenance of stable staff roles, clear-cut and predictable lines of authority, firmly and equitably enforced rules of dress and conduct to which patients are expected to adhere, and rapid and effectual staff communication and consensus regarding every aspect of the patient's daily experience and behavior. Within such a setting, the residential psychiatrist assumes leadership of the ward or cottage therapeutic team, which is composed of the nurse and psychiatric aides or child-care workers.

The residential psychiatrist possesses final authority in determining and implementing the overall therapeutic plan for each patient, in collaboration with the other ward or cottage staff members, and prescribes indicated educational and adjunctive therapeutic activities and classes. The residential psychiatrist collaborates closely with the caseworker or family therapist, and with his patients' group and individual psychotherapists, none of whom carry administrative responsibility for the ward or cottage treatment areas.

Ideally, an intensive residential psychiatric service should be reasonably

self-contained; if the adolescent service is a part of a larger general, teaching, or public or private mental hospital, its staff should be able to evolve and implement its clinical-administrative program devoid of coercion or pressure to conform to general institutional rules inapplicable to an adolescent residential program. Its ongoing diagnostic and therapeutic work should be carried on, with but rare exception, only by full-time staff members. By and large, part-time visiting or attending staff, lacking comprehensive daily knowledge of the patients, complicate the therapeutic work by falling easy prey to the adolescent's redoubtable tendency to manipulate them and to split and divide them from the full-time staff members.

If the residential setting also serves as an affiliated teaching service, it becomes essential for the various trainees, particularly the general and child psychiatric residents and fellows who serve as residential psychiatrists, to receive intensive supervision by experienced senior staff members who are themselves actively immersed in the therapeutic work of the service. Such supervision, which not rarely assumes therapeutic qualities, serves to expose and minimize the serious transference-countertransference binds that trainees are prone to experience in their work with seriously ill adolescents. The same is true as well for the various full-time staff members themselves, for whom individual and group-process in-service training and supervision are ongoing needs.

Group and Family Therapy

In a very real sense, the therapeutic ward or cottage program comprises a more extended form of group therapy. For the hospitalized adolescent, formal, dynamically oriented group psychotherapy has a definite place, subject to several qualifications:

1. Formal group psychotherapy is optimally conducted with a mixed- or same-gender group of adolescents numbering not more than six, with or without a recorder, in addition to the group psychotherapist.

2. Group psychotherapy is contraindicated for pre-symbiotic adolescents until they are well along in the definitive phase of treatment.

3. Group psychotherapy is of little therapeutic value and may indeed exert negative therapeutic effects in the case of symbiotic adolescents during the resistance phase of treatment; that is, before they have engaged with the ward or cottage staff. The exception is the psychotherapeutic group conducted directly in the ward or cottage treatment area, integrated into the mainstream of daily ward or cottage activities.

4. With hospitalized adolescents, the conduct of the group sessions should follow a carefully prescribed and enforced structure regarding time and place, promptness of arrival, and behavior during the sessions. Although the patients may in various degrees participate in setting and maintaining the

> structure, a passive, or laissez-faire, approach to it by the therapist is contraindicated. The notion of participatory democracy in an adolescent residential service is often an illusion that disguises staff countertransference and scotomatizes the adolescent inpatient's very serious difficulties with ego functioning. The therapist must therefore unequivocally convey to the group that he is in full and complete control of it at all times.

Again, regularly scheduled meetings between the hospitalized adolescent and his parents, under the supervision and with the scrutiny of the caseworker, constitute a form of family therapy of particular diagnostic and therapeutic value to all concerned, especially as such meetings serve to promote exposure and resolution of the parents' and the adolescent's resistances. The parents should have their own meetings with the caseworker for discussion of problems not directly related to their difficulties with their child, as well as for consideration and analysis of the events that transpire during the patient-child meetings, as these may be correlated with the details of the child's ongoing work in the ward or cottage.

Residential School and Adjunctive Therapies

The therapeutic and specific values of residential school and of occupational and recreational therapies lie in their firm integration as parts of the overall therapeutic program of the residential treatment service, and not

as ends in themselves. Thus, the teachers and the occupational and recreational therapists have concomitant status as full therapeutic team members, and the specific skills they impart or catalyze sub-serve the adolescent's particular therapeutic needs.

In the case of the pre-symbiotic adolescent, the disorganizing effects of peer competition necessitate assignment to the one-to-one class. In school, the specific goal of imparting basic cognitive skills succeeds only if the student-teacher relationship flourishes. Often, the residential teacher becomes, in effect, the adolescent's psychotherapist, as she labors to catalyze the youngster's blighted capacity to learn. The same general considerations apply to occupational and recreational therapies, in which the therapist utilizes specific professional skills and modalities to generate and reinforce the nuclear object relationship so essential for the process schizophrenic adolescent.

In the case of the symbiotic adolescent, residential school and adjunctive therapies represent opportunities for de-symbiotization. In them, the symbiotic adolescent is urged toward competition and socialization, with ensuing exposure of his infantile grandiosity and opportunities for relinquishing it through the consensual process.

In all cases, the therapist must set and maintain a firm structure in

which the adolescent is expected to perform and must be skilled in therapeutic process in addition to the specifics of his or her particular professional expertise.

Some Pitfalls of Residential Treatment

The variety of pitfalls common to residential therapeutic services for adolescents amount, on careful analysis, to symbolic repetitions of the antecedent de-personifications to which the adolescent inpatient has previously been exposed. To them, the patient responds either directly or metaphorically with the message, "You don't understand me!" Under such circumstances, the patient has three alternatives. (1) He may dissimulate and appear to comply. (2) He may proceed to act out and "raise the roof." (3) He may run away.

Some of the common pitfalls are:

1. Substantive and euphemistic mis- or under-diagnosis of the borderline or frankly psychotic adolescent with such labels as character disorder, psychoneurosis, adjustment reaction, or some form of deviant development.

2. Countertransferential adultomorphization of the adolescent, reflected in laissez-faire, over-permissive, pseudo-analytic, and pseudo-democratic approaches, which profoundly overestimate the youngster's coping and adaptive capacities

and scotomatize his difficulties with self- and sexual identities.

3. Open-ward treatment of the adolescent during the resistance phase of his work, prior to engagement with the ward or cottage staff.

4. Capitulation to the warding-off demands inherent in the adolescent's regressive actions and experiences during the early part of the definitive phase of treatment, thereby terminating his underlying need and efforts to desymbiotize.

5. Failure to regulate and control parent-child correspondence and visits, and consequent failure to effect parent-child separation, with resultant persistence of their mutually de-personifying communications.

6. Failure or unwillingness to utilize necessary legal controls to ensure the adolescent's continued residential treatment during those times when his and his parents' fear of exposure of their pathogenic nexus motivates efforts to remove the patient against medical advice.

7. Premature or willy-nilly use of individual psychotherapy for the symbiotic adolescent during the resistance phase of treatment.

8. Use of part-time, visiting, or attending staff members and of school classes and adjunctive therapies not intimately integrated with and subservient to the basic therapeutic purposes of the residential service.

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Notes

1 Masterson independently described three analogous phases in the intensive psychiatric treatment of the adolescent with borderline syndrome: his phase l, testing, corresponds with the resistance phase, his phase 2, working through, with the definitive phase, and his phase 3, separation, with the resolution phase above described. Lewis,20 also working in a residential setting, confirmed the phasic nature of adolescent residential treatment, with particular emphasis on resistance and later introjection.