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RESIDENTIAL TREATMENT OF EMOTIONALLY DISTURBED CHILDREN

American Handbook of Psychiatry

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e-Book 2015 International Psychotherapy Institute

From *American Handbook of Psychiatry: Volume 5* edited by Silvano Arieti, Daniel X. Freedman, Jarl E. Dyrud

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Residential Treatment of Emotionally Disturbed Children

Residential treatment is a form of therapy that involves the total life of a disturbed child in a planful organization that is built upon a defined theory of treatment. It requires the child to live in a special setting, where he is cared for by trained personnel who mold their everyday interactions and relationships with him toward therapeutic ends. Characteristically, within a residential treatment center (RTC), a host of specific therapies are present that are organized around a common strategy of treatment. It is this quality of integrating the details of everyday living with a wide variety of therapies that gives residential treatment its unique character. In particular, this pattern of treatment usually includes the child's family, either as individuals or as a family unit.

On the whole, residential treatment tends to be a long-term rather than short-term approach, and it is typically directed toward children who are not severely retarded or extremely regressed. It is to be distinguished from the services delivered by those special schools, hospital wards, or other settings where education or other forms of treatment are provided but no conception of an intensive, totally structured, and integrated therapeutic life prevails.

Types of Residential Settings

It is evident that the number of variables that have to be meshed to create a residential treatment center is very large. Hence it is not surprising that these settings vary in organization to the extent that almost each center is unique. There are, after all, a great many ways of combining so many treatment details. The number and variability of the patterns that can ensue are enormous, and actual descriptions of individual settings show a predictable lack of uniformity. Moreover, these settings have emerged from many different backgrounds, which in turn has resulted in further degrees of variety and differentiation.

Without trying to be complete, a few characteristic types of settings can be mentioned to illustrate something of the richness of character of the existing patterns. It is obvious that many new permutations and combinations will appear as time goes on.

1. *The school-centered program.* Here the name of the agency often identifies it as a school, and the program is built largely around an academic core. However, classes are often as small as one or two youngsters per teacher, and teachers may act as childcare personnel after the school hours are over. Psychiatric and psychological consultants are usually part of the environment and may be on the staff. The children are considered pupils rather than patients, even though each one is in psychotherapy and/or group therapy and/or drug therapy (all of which are part of the total treatment plan of the setting). Characteristically, there is a

central emphasis on the milieu as therapeutic.

2. *The casework program.* Typically, the agency is administered by a social worker who gives direction to a staff of caseworkers or group workers. Psychiatric consultants or resident psychiatrists may be part of the scene, but the children are viewed as clients rather than patients. The actual child care work may be done by live-in house parents, social workers, or trained child care workers who rotate through shifts. Again, however, milieu therapy is central.

3. *The hospital or ward setting.* Here the basic pattern is that of a small mental hospital largely staffed by nurses and nurses' aides. But where the unit functions as an RTC, the nurses usually do not wear uniforms and they work much as the child care workers do in other settings. The doctors write orders, but they may play a role not dissimilar to that of the psychiatrist in the casework agency. Often enough a psychologist or social worker is ward administrator, and the actual details of hospital organization are looked upon as irrelevant or as minor irritants that get in the way of delivering the basic service: a wide spectrum of specific therapies integrated into a therapeutically oriented pattern of living. The quality of staff interaction and the emphasis on developing a therapeutic, child-oriented life style give the setting its basic flavor.

Administrative Structure

As is evident from this account of models, no single pattern or even

philosophy of administration governs all residential settings. There are a few pervasive concepts that need to be noted, but even these are protean in form and dimension as one passes from center to center.

1. *Team-oriented administration.* The most common style of bringing together a group of therapists around a single case is to structure a team of professionals for each child or each small group of children, and to consider this team as the essential deliverer of treatment services. The team would have to include all the people actively involved in the child's life. Typically this would involve the child-care worker, the parent worker, the individual and/or group therapist, and the teacher. In a hospital-type center three to five disciplines might well be represented at each team meeting, whereas in a casework center social workers and a teacher might form the whole treatment group. In any case, the keynote of their work is collaboration. The exchange of information, opinions, and ideas among the various team members, and the formulation of a common concept of what the child's behavior means and how to cope with it are the essence of the treatment. Whatever service impinges on the child is a function of this kind of mutual interaction. The team leader may be any member or a consultant or someone non-designated who emerges from the group interaction.

2. *Authority-oriented administration.* In such settings a single dominant leader deals with the team members. He meets with each team, tells them what the patient's behavior means, interprets to them the nature of their

countertransference, and formulates the treatment plan that they are to follow. He may address the team as a group, or he may work with each member individually, sharing information and explaining what needs to be done in a one-to-one context. In such settings, the discipline of origin becomes particularly unimportant and the psychiatrist may work as child care worker under the direction of the psychologist leader, or both psychologist and psychiatrist may take direction from a social worker.

3. *Therapist-dominated administration.* Here the accent is on the work of the individual therapist. While a unit administrator actually cares for the details of everyday organization, the team takes its direction from the child's therapist. He formulates the picture of the child's needs at the time, and the way in which the team can answer them. He sets the tone for the child-care work and indicates the atmosphere that he thinks should prevail at school. He weighs programmatic details and decides whether or not a visit is indicated, a restriction is called for, or a special conference needs to be held. However, he works closely with the other team members and considers it his responsibility to see that they understand the patient's dynamics.

History of Residential Treatment for Children

A number of different agencies that sought to meet the needs of different groups of children have gradually converged on the patient population they selected, and they have developed parallel means of coming

to grips with the problems the youngsters presented. One major source of such centers was the old-style orphanages of the nineteenth century. These settings gradually woke up to the fact that they were handling fewer orphans and more and more children who were dependent, neglected, and disturbed. They began to call in consultants and hire specialized staff people and, finally, to change their charter altogether. Many of today's residential treatment centers began in this way.

A second source of such agencies was the hospital units created for brain-injured children. With the accumulation of experience and the passage of time, such units began to devote themselves to youngsters with primary emotional difficulties.

A third source of residential care came from schools for retarded youngsters. Many such schools continue to exist today; but here and there, what had started out as a special or remedial educational institution altered its character and began to focus on the troubled child who was not retarded. Curiously, there has been a tendency in recent years for centers that had previously excluded children with low IQ's to begin to accept and to treat them in greater numbers than ever before (when appropriate emotional disturbances were present).

A fourth channel for the creation of residential treatment flowed from

settings for delinquents. The old-time reform school with its tradition of strict discipline and total obedience has in at least a few instances given way to a more therapeutically oriented, group-life program in which regular casework and consultations attempt to integrate milieu principles and psychotherapy into a treatment pattern. Such "conversions" have been less frequent than the transformations of schools and orphanages, but they have occurred.

In recent years a number of settings have come into being de novo, designed as residential centers from the very beginning. Some of these are being constructed today in connection with community mental health centers, while others have been established as autonomous units or in connection with a variety of other settings.

Inevitably, such a movement as residential treatment has developed its core of shared principles, practices, and methods. At the same time it stands in equilibrium with a series of alternative methods and approaches that share with it some common principles but differ from it in significant ways. One major difference in method has been to challenge the reliance on psychotherapeutic or casework principles as the central core of values in the approach to treatment. In recent years a series of settings have appeared that avoid this element. They instead seek to build their methods around a common-sense, didactic model in which behavior is considered as something to be taught, rather than interpreted, and modeling takes the place of

interviewing as a vehicle for change. Some of these settings, taking their cue from the French *educateur* experience, are called "RE-ED." (The educateur is the basic staff person in the French welfare and delinquency settings.) Others, working along similar lines, have been part of the American scene for a long time as homes for homeless children (e.g. Boys' Town) in which an atmosphere of repair and rehabilitation prevails, based on common sense or on religious principles. The essence of such experiences as RE-ED and others is that they offer the child a break in the continuity with the home environment, an alternative encounter with a "healthy-minded" staff, a great deal of focused attention on behavior that disturbs the environment, and a relatively rapid return (after three or four months) to the home setting. The major differences between such approaches and residential treatment are the former's strong de-emphasis on therapy, the lack of an integrated therapeutic milieu, the reliance on identification, modeling, and behavioral instruction as the primary agents for change, and the brevity of the experience. In a sense, these approaches are both less intensive and less extensive.

In contrast, there are a number of treatment styles now emerging in which the intensity is as great as and possibly even greater than the residential approach, but in which the extent of treatment is less. This is seen in many of the day-hospital settings that are now appearing. The essence of these programs is to provide an active therapy approach, which may include therapeutic school, occupational therapy, an individual therapy hour, a group

therapy session, and a family therapy encounter all in the same day. The youngster spends a good part of his weekday in an intensive, integrated, therapeutic milieu five days a week. He goes home each afternoon and stays there all night to return to the program the next morning, then stays home for the weekend and re-enters treatment on Monday morning. Or the full residential program may continue on a live-in basis five days a week, with the child going home each weekend.

Thus many variations of the basic pattern have been established by now, and more are being experimented with. Some settings have abandoned individual therapy and instead focus exclusively on group tactics and methods for regulating the daily life in the setting and exploring each individual's personal history and character. Such an approach is often seen in the group homes and halfway houses that so often help youngsters to make the transition from penal or therapeutic placements to total responsibility for their own care and therapy in the open life of the community. This kind of group-oriented living takes on some of the character of the therapeutic community, in which the essence of the approach is to have regular and frequent group involvement in issues of care and in decision making.

Intake of Children

Selection

The traditional age group referred to RTC's has been the latency-puberty group, roughly from the ages of six to fourteen. Many settings have limited the upper intake age to twelve or thirteen and then kept the youngsters to fourteen or fifteen. Others have preferred to deal with smaller children who are physically easier to handle and do not present the complications of puberty.

Every setting expects children to be action-prone to some extent and has to think and plan in terms of how to manage acting-out. As a result, relatively few centers attempt to care for older adolescents, with whom such problems can become grave and, not infrequently, overwhelming. However, there are a fair number of RTC's that concentrate on the middle adolescent group, with an upper age limit of sixteen or seventeen. Curiously enough, a movement has begun toward extending the age of residence downward and accepting preschoolers for such care. This is parallel to and perhaps in equilibrium with the concepts of day care emerging in the United States. In any case, there are now some voices speaking for the acceptance of younger children.

Many RTC's accept only boys. There are two reasons for this. (1) There are perhaps three to five times as many boys referred for such care as there are girls. This is true of the pattern of referral of children for psychiatric treatment in general: boys form the largest proportion of the applicants for

service to outpatient clinics, to private practitioners and indeed to all mental health facilities. In this respect it is also important to remember that most RTCs are small; their census runs in the tens, not in the hundreds. In the face of the scarcity of female referrals, the needs for appropriate facilities, different staff, and a whole additional set of concerns pose a very considerable burden. (2) Many professionals have observed that the girls who are referred for care are typically much sicker than the boys who tend to apply. Since an important criterion for program planning is the level of pathology that a particular setting accepts, this has automatically ruled out many girls from such possible placements. On the other hand, quite a few centers, especially the large ones, keep an active girls' unit as part of their range of treatment facilities and welcome the opportunity to work with this group. This is perhaps more likely to be the case where puberty-age and adolescent youngsters are accepted, because at this age the level of referral of females picks up sharply.

Reasons for Referral

The reasons for referral to such treatment are manifold. The placement of a child in residence involves his total removal from home and is at best a major disruption of his life. It may be a major relief in certain situations, but by and large one must view it as a traumatic event and initiate such a pattern only in the face of clear-cut need. Optimally, no youngster would be accepted

who has not had a previous attempt at outpatient treatment or day care.

In any given case, the character of the need for placement requires careful weighing. Generally speaking, referral is indicated when the youngster's horizons for successful adaptation have shrunk to a very narrow band or have disappeared altogether. Thus if withdrawal is the dominant issue, the child would have been too shut in to profit from school or from neighborhood and community activities, and might now be starting to remove himself even from family life. Attempts at therapy have been fruitless. Now residential treatment is the next appropriate recourse. Again, when issues of depression or of phobic or obsessional symptomatology are in the forefront, the degree of incapacity should be considerable before resorting to such care. Indeed, where neurotic configurations predominate, the indication for alternative forms of treatment is particularly strong. Only when both the emotional crippling and the failure of outpatient therapy are marked should such a referral ensue.

By and large, borderline children with various behavioral and neurotic-like symptoms form the largest group in residence. Their failures in adaptation are of sufficient severity to keep them in a turbulent and troubled state of interaction with their human environment. Their need for relationships (and for coping with the aching void of separation emptiness that is so characteristic of their syndrome) makes them appealing, needy

people who, often enough, turn out to be good treatment cases. It is true that frankly psychotic children are often taken in as well. Nonetheless, more overtly bizarre and uncommunicative children are frequently not accepted or are referred to a few hospital or hospital-like settings that have a larger tolerance for such regressive symptoms. Fortunately, however, there are a relatively few highly specialized RTC's that accept primarily autistic or severely psychotic children.

One major grouping of children often referred for treatment in residence is the one gathered under the term "behavior disorders." This rather diverse diagnostic category includes a wide variety of dynamic conditions. They range all the way from true sociopathy, in which the child will act out his impulses quite naturally, without anxiety, and with no sense of personal discomfort unless he gets caught, to the criminal-from-a-sense-of-guilt type of masked depression, in which the youngster tries to provoke the environment into punishing him in order to avoid the far more horrid threats of his cruel and implacable superego. Many children are referred to residential care because of bad behavior. It takes careful diagnostic screening to sort out those who need interpretive and ego-supportive therapy from those who need limits, education, structure, and patterning. Not all residences can do all kinds of treatment, and it takes a very special orientation to cope with the severely psychotic or the inflexibly antisocial character disorder.

There are also instances in which it is best *not* to refer a youngster for residential treatment. One, obviously, is when he needs a different kind of care but no other type of service is convenient. To place in residence a child who could be treated at home is simply bad medical practice. It is like a surgeon operating when conservative medical treatment is indicated—it may indeed be a way to obtain relief, but it still isn't right. Another instance is when the youngster's difficulties created by separation from his family would be more catastrophic than continuing to live with the symptoms. This type of situation ensues where a youngster has had a number of serious losses and is clinging to his current relationships in a way that is as desperate as it is destructive. When admission is contemplated at all in such a case, the optimum approach is to enter into a prolonged process of trying to work the child into the setting gradually. Thus, he might visit the setting once a week or even once a month for several months, and then spend a night or a weekend, bit by bit overcoming the separation panic as he begins to use the residential facilities. Indeed, as we shall presently see, placement in general is best done as part of a process of engagement, with a period of anticipatory planning and (where possible) a more or less gradual working through of the actual admission.

Steps in the Intake Process

When we talk of picking children out of one setting and moving them to

another, we always need to keep before us the reality of the stress such moves pose for the immature ego. This is true even when an intact family moves as a unit to a new neighborhood or a new city. Many a child suffers no small sense of wrenching loss and real depression under such circumstances, despite the support of his parents and siblings. The practice of sending children off to camp for the summer also has its quota of failures and of unfortunate adjustments, even though the accent is on fun and pleasure and even though it is self-limited and only for a few weeks or a couple of months. This is not to say that most children cannot handle such stress and come out of it better than they went in. They can and do. Rut the important point is that it *is* a stress. It takes a good deal of coping and mastery, and the hurt child may find this especially hard to manage.

The Preliminary Study

When we swing away from these everyday situations and face our current concern, the matter of taking a child out of his home and putting him into residential care, we have to weigh a number of additional elements. The child has already been in big trouble. He typically feels himself—and often enough is—the family reject, the troublemaker, the scapegoat. His leaving home has about it something of the feeling of failure become catastrophe: he wonders if he is really being sent away as punishment; he wonders if he will ever be accepted back. His parents tend to feel a mixture of guilt, relief, and

shame as they simultaneously admit defeat, seek succor, and rid themselves of what has become an intolerable burden. Clearly, such a congeries of disturbing feelings needs the most careful and sensitive sorting out for diagnostic understanding, and a planful and supportive approach in order to try to make the intake experience as therapeutic as possible. Typically, residences require at least a visit or two by the child and family to allow for study and, in turn, to allow the prospective client his chance to spend time in the setting and to get a feeling for its atmosphere and its ways. All of this is of primary importance in making the transfer from home to residence. When there are many reservations about entering treatment, every effort should be made to extend the period of evaluation and preparation for admission. Even if it takes a year to move a child into residence, the ensuing year will be infinitely more therapeutic than if the youngster is forced despite his terrified opposition and thus started off in a totally negative way.

The nature of the preliminary study is similar to that of the conventional pattern for mental health diagnosis, with special extensions along some additional dimensions. The child is usually seen in a playroom interview, psychological tests are administered, the parents are seen in one or more sessions, not uncommonly the whole family (including the candidate for admission) is seen as a unit, a physical exam (sometimes with a routine neurological evaluation) is carried out, and previous school and therapy records arc reviewed. The special work done for residence study involves

having the child attend school for a day, putting him in (perhaps for an afternoon) with the living group he would be joining, showing him where he would sleep, and, if possible, having him and perhaps his family eat with the children in residence at one or more of the regular daily meals.

The observations gleaned by the staff during this series of interactions are made part of the record and of the ensuing intake conference. This conference is the site where all the clinical material and the current observations are reviewed and a decision is reached. The issues to be considered include whether or not the child should be admitted; if he should be, how the process should be carried out; once carried out, what kind of program he would need in the residence; while he is in, what sort of support and communication structure his family would require; and once in-house treatment is at an end, where he would go. It is only when such a clinical review has been accomplished that one can say that admission is indicated. No residence does itself or its patient a favor by accepting someone it cannot treat effectively.

In actual practice it might take several years and a host of trying experiences before a given center becomes sure and clear of its therapeutic identity, before it knows what it can do and cannot do and admits patients accordingly. Typically, when a new agency of this sort opens its doors, it initially tends to receive a spate of referrals of children who have gone from

agency to agency and setting to setting in that community, always failing and ever and again being transferred, discharged, or simply dropped. Often enough, if a number of patients of a certain kind—for example, suicidal children, youngsters with severe sexual acting-out, runaways, or whatever—are accepted at the outset, the agency becomes known as the proper site for that kind of referral, and that's what it will tend to get for some time. Hence it behooves the staff to be especially circumspect at the outset in order to avoid accepting cases they cannot help and to prevent themselves from being "type-cast."

The Matter of "Fit"

The evaluation of patients for admission to residence is an art form of considerable sophistication. The criteria of admission are both general and specific. They are general in the sense of a given age range, a given sex, a given IQ, a given set of inclusive or exclusive diagnostic categories, and the like. They are specific in the sense of "We will only accept patients whom we feel we can help" or "We will only accept patients who have an adequate family group to work with who will accept responsibility at the time of discharge," or "We evaluate new patients in terms of how they would fit into our existing treatment groups." In effect, this means that from the array of possible candidates who meet the general criteria, a given child might be accepted or rejected at a certain moment because the setting is adjudged to

"need" a more withdrawn case to balance an overabundance of acting-out children. A youngster with more behavioral problems might be indicated because there are too many quiet schizophrenics in residence. A girl might be preferred rather than a boy because there are too few girls. Or the setting might be trying to achieve a certain racial balance, and so on. Since the matter of group composition is a vital factor in the success or failure of a treatment venture, these specific determinants are fully as important as the more general characteristics; indeed, they may be more important.

What concerns the intake staff members is the general matter of "fit." They seek to determine if they have the proper therapeutic "mix." (The repeated resort to quotation marks around these words indicates the intensely subjective character of some of the decisions that have to be made.) One sizes up a group, one sizes up a treatment staff, one sizes up a child; and the question becomes—given the existing group, the available staff team, and the particular make-up of the new applicant— what are the chances of the child doing all right if they are all put together? What will the new group be like, and how will the current staff group interact with this changed group composition as well as with the new child? There are obviously a great many unknowns in all this, and the fundamental importance of highly trained, highly experienced, clinical know-how can scarcely be overestimated.

Planning for Disposition

The matter of disposition is a critical factor for treatment; it is standard practice to begin planning for discharge at the time of intake. This usually implies a careful evaluation of the family and the preparation of the family for the eventual discharge of their child. Obviously not all children return home, so this possibility sometimes needs to be considered from a very early moment in the management of the case as well. Many centers will not accept a child whose home is just breaking up or a child who is being separated from the last of a series of unsuccessful foster placements. The child is refused because the staff insists on having a secure home base for the youngster outside the setting. They view this as part of the treatment. They look ahead to Christmas and Easter and summer holidays, when so many children can at least visit home, and they know that sooner or later placement plans will have to be faced. This can be a major stress for an agency—to have a child who is ready to move on, but for whom there is no setting available to move on to. Thus, as a condition of intake, disposition patterns must also be clear.

Many would-be treatment centers are supported by the state or county and are required to take all admissions as long as they have beds. Thus, the Juvenile Court judge or the Department of Welfare or the mayor has the authority to require that a child be admitted. This requirement is enough to differentiate between a treatment setting and a would-be treatment agency—in the parlance of the residential treatment professionals, ". . . if you cannot control intake, you're dead." And indeed they speak from long-range and

intensive experience: the composition of a treatment group and the proper fit of each new patient represent the difference between a true therapeutic situation and a holding, warehousing, or survival effort. If the setting is to be a valid treatment environment, the treatment team, and only the treatment team, must control intake.

Methods of Treatment

The essence of residential treatment is the reality of the setting itself. If properly put together, it is a dynamic organization of many elements to express a central theme. The theme is likely to vary from agency to agency, but it will be implicit in everything: the choice of wallpaper or paint colors, the layout of the day hall, the choice of rugs and furniture, the quality and timbre of voices in which people speak, the way staff dress and walk, the posture and facial expressions of the secretary and the director and the social worker and everybody else, the kinds of play equipment available, the average level of order and cleanliness in the setting, the degree to which groundskeepers and kitchen help and laundry personnel and all the rest know and feel themselves to be part of a treatment project, and on and on. Such details give a setting its character and atmosphere. Not only are they the context in which treatment takes place, they are in themselves primary elements of the therapeutic process; they are part of and state the theme. The theme may be a very simple one: "Here you can relax and be yourself and we

will take care of you." Or it can be: "Our people won't let you get hurt, they won't let you get away with things, but they will help you understand yourself." Or perhaps: "Here we take kids who've been in lots of trouble and we have to hold onto them pretty tightly. But we also care about them and we always find a way to help."

Sometimes a particular therapeutic style can dominate the atmosphere. Thus, some residences build their treatment program around work with families. They see the role of the residence primarily as one of protecting child from family and family from child while it brings both of these warring parties together in varying contexts and at regular intervals, in an attempt to detoxify and restructure the internal life of that family group. Another therapeutic setting may regard the individual psychotherapy as central and the residential life as a sort of sanitary environment that holds the troubled child and meets his needs more adequately than the family could, in order to allow the therapist to do his work. Or a group orientation can prevail in which the emphasis falls on various patterns of group interaction—day hall meetings, cottage meetings, school assemblies, classroom groups, therapy groups, whole unit meetings, whole families as units, and groups of families as therapy units—all of them concerning themselves both with the issues of everyday living and with the details of individual psychopathology. Still another style of structure emphasizes the behavior model approach. Such behavior techniques are finding an ever-increasing role within residential

treatment, and there are some settings in which the basic strategy of engagement involves schedules of reward and of patterning behavior.

Each such "method"-dominated environment will of course emphasize its particular technique as its central theme, and the organization of the life it creates will speak for this theme. But in the long run, most settings are far more eclectic and their themes are far more complex. They utilize all these treatment modalities and more; indeed, many take pride in the richness of their treatment resources and the number of possibilities they can invoke for any given case. Their theme then becomes one of living in an open, communicative, and engaged way as the essential stepping stone toward health, while finding the specific treatment equation needed by the particular child within the total context of the residential life.

Much of what these settings are is a reflection of the character and the values of the director. Residential treatment is not run according to democratic principles, or even very much by consensus. The director sets the tone as well as the limits of what the setting will do, and his interactions with his staff will provide the model for much that will presently be transmitted to the children.

The Milieu as Treatment

In keeping with the notion that the overall setting is a basic treatment

modality, a great deal of careful thought has gone into what Redl called "the ingredients of the milieu" (1957). What has emerged is a major emphasis on programming and an even greater commitment to the tailoring of the interpersonal life of staff and patients toward the goals of treatment.

Programming

The use of programming is one of the most neglected therapeutic skills (Foster, 1972). It deals with the structuring of time and the prescribing of activity for the individual's life and for the group's life, and it depends on an accurate reading of individual and group dynamics in terms of needs and potentialities.

Time is framed for patients in a variety of ways. There are the time relations of holidays and special events. There is the rhythm of visits, both from parents and to them. There is the structure of a given week, with its weekday work-school quality and its weekend relaxation-recreation atmosphere. There is the time frame of the individual day, with its many possibilities of alternating educational and large muscle sports, and fine-muscle focused crafts, social interactive, solo contemplative, adult-oriented, and peer-group-structured moments. There are the choices of therapies: individual, group, family, behavioral, occupational, remedial, speech, music, art, recreational, work, and so forth. And there are the contrapuntal cadences

of sublimatory play-expressive experience; the hike; the party; the game; the museum tour; the boat trip; the spectator-sport or participant-sport event; the police-station or fire-house or garbage-disposal-plant visit; the magician, the clown, the TV star, or the disc jockey, come to the unit to perform . . . One could go on at great length detailing the myriad experiences that creative and imaginative programmers build into children's lives as part of the flow of therapeutic matrix elements that is milieu therapy. For the residential therapist, time is a supple, plastic stuff that he molds and shapes into the countless irregular forms that fit within the administrative limits, the logistical and financial possibilities, and the peculiar temperament of each patient-staff group, and the individual needs of particular persons within the group. Good programming can serve as a powerful instrument for healing a sick child. Nothing is more expressive of the essence of residential treatment than the program that the environment develops.

Interactions

Along with time, the second great therapeutic instrument in this work is the "other person." Children are already enormously vulnerable and needy and reactive to adults, and sick children are reactive to a degree that far transcends conventional social experience. Their every interaction holds within it the potential for remediation or for trauma. It was the recognition of the power of human interaction—even of the most banal variety, around the

most pedestrian subjects, during the most humdrum and everyday exchanges, at the most inconspicuous and workaday level—in other words, the recognition of the extraordinary force of the ordinary in children's lives that led residential therapists to the formulation of these basic principles. In brief: in the ideal RTC, every human interaction between staff and patients would be a therapeutic one. To the extent that the work with the children approaches this ideal, the therapy will be optimal (Bettelheim, 1950; Bettelheim, 1967; Mayer, 1971; Redl, 1957).

In practical terms, this means that each person in such an environment knows something about the needs of the child and what it will take to meet those needs. There is a careful formulation of the meaning of the youngster's behavior. What is he warding off? Where does he feel weak or afraid? How does he act to protect himself? Why does he attack a given person, at a certain time, and in a certain way? And there is an equally thoughtful attempt to decide what is the best response to make to each of these aspects of the child's behavior. Here is a shut-in child who is beginning to be aggressive. Does one make a joke about it, or does one set limits, or does one congratulate him, or does one ignore the behavior? Is there an interpretation that should be made? This thinking-through of the everyday behavior in the child's living space constitutes much of the work of such treatment. To the extent that adequate responses are found, the work will have a good outcome.

Life Space Interviewing

In this connection, a special kind of interviewing skill has developed. Its originator, Fritz Redl, called it "life space interviewing." In brief, it seeks to utilize the moments of stress in everyday living as primary sites for therapeutic interaction. If a child gets an upsetting letter, or hits another child and runs and hides, or is the victim of such an attack, or gets upset for any reason, or acts in some inappropriate way, the event becomes (within this particular framework) a signal for an interview. The interview will be conducted by whatever staff person happens to be present and part of the experience. It takes place there and then, at the site of the happening (or reasonably close by); and as close in time as possible. Sometimes, with a very upset child, two people have to share the interview while they contain him. Indeed, the interview might take the form of dialogue between these people about what the child is going through as he struggles or cries or hides; they talk to each other about what it all might mean.

These interviews are therapeutic, but they are not psychotherapy (Redl, 1957). Often enough they will seek to define certain behavior or feelings as problems that should be taken to the therapist or brought up in the group. Or they may strive to strengthen the child's ego, to bring the youngster back to reality, to restore a sense of structure and limits, to provide a bridge of acceptable and accepting human interaction and human warmth and interest,

to divert the child from obsessive brooding and self-recriminations, to put salve on the teased youngster's deep narcissistic wound by finding something to praise, to dispel a sense of loneliness and emptiness that may have suddenly become overwhelming, and so on, for the many necessary bits of healing experience that will presently form the mosaic of treatment. Or they may try to set bounds on impulses, to limit the scope of action patterns, to draw the fangs of revenge fantasies, to define structure, and to speak to the realities of order and the limits of social tolerance.

Generally speaking, "life space" interviews try to convert everyday issues into therapeutic experience and to provide a form of skilled crisis intervention that makes each point of stress in the child's life a site for potential mastery and progress. Like other crisis interactions, they are not easy to conduct. It takes a great deal of training and group interaction to develop the consensual values and the appropriate level of skill that will allow a staff to use this instrument effectively.

Such interactions are not limited to one child. There are many moments in residential work when group "life space" interviews are necessary, when one or more staff members sit down with youngsters involved in a particular escapade or mass reaction of some sort and deal with the issue of how the group functioned. Indeed, in settings with a primary or a major group focus, much individual problematic behavior is seen as a group responsibility, and

the group is restricted or deprived when the individual child acts out. With such an approach, powerful group pressures can be brought to bear on each child in the service of maintaining the integrity of unit life.

In many instances, a given child needs certain freedoms or limits or other programmatic structures that are unique for him. He may have a talent that should be specially developed or an interest that can be exploited to further his education and/or his treatment, or else some programmatic variation is possible that will make him feel specially cared for at some moment of unusual need. Such variation is essential. It is a vital dimension of treatment, and it requires the staff to be able to say to each patient something to the effect of: "Johnny gets something exceptional when he needs it, and when you need it we will do something very special for you, too." There is, however, an endless balancing act that is necessary between the needs of the group and the needs of the individual. The important thing is to preserve enough degrees of freedom to allow a unit to function in either realm.

Psychotherapy

Various residential settings have included all kinds of therapies, from psychoanalysis (or intensive psychoanalytically-oriented psychotherapy) through the whole range of individual interview therapies (Ekstein, 1966; Robinson, 1957). At the other extreme of the spectrum is the group of

behavioral therapies—the system of approaches that arise from theories of conditioning, both operant and classical. Behavioral therapies are currently being tried, sometimes in an experimental way and sometimes as the established treatment of choice. Since, in fact, residential treatment tends to be eclectic in its values and methods, behavioral therapies will in fact find an appropriate place in time among the roster of available methods. The implications of suppressing specific behaviors are not yet thoroughly understood, but the value of doing so in certain instances is self-evident. However, the problem for the residence, again and again, is how to use the relationship with the therapist—that is, how to integrate the therapist's understanding of the child into the total program. Hence, it is impossible to discuss the role of psychotherapy (be it group, individual, or family) without commenting on the problem of collaboration.

Psychotherapy in residential treatment is inherently less confidential than it is in outpatient situations. Since the whole staff and the entire milieu structure strive to be therapeutic, one cannot so easily draw a distinction between the therapist and the non-therapists in the situation. Treatment is everybody's business, and it is a two-way street. Sometimes the patient will select as the object for his confidences someone who is a member of the kitchen staff or who serves as unit handyman. Indeed, the youngster may tell very little of what he thinks to the actual designated therapist. Therefore, to conduct the individual work in a serious way, the therapist needs constant

input from whoever is receiving the child's communications. To keep that person, (and indeed the whole team around the child) functioning well, the therapist must constantly feed back to his teammates a sense of what is going on in the youngster's mind, what his behavior means or might mean, what he is hiding and revealing, and what he needs and what he seeks to avoid. The other team members, in turn, each have their areas of expertise and special access to the patient, and each will have a contribution to make. Indeed, often enough, the key to what a complicated behavioral pattern or difficult attitudinal set is all about may come from the teacher's observations in school or what the caseworker learned on a home visit (Trieschman, 1969). In any case, it takes an active and mutually respecting exchange to make the therapist's input useful and functional within the residential life.

All residential work is directed toward groups of patients, although many settings do not include formal group therapy sessions. However, there is always some sort of ward meeting or cottage meeting or unit assembly that brings together child-care workers and patients for a review of the current status of unit life. These meetings may occur every day or several times a week. Sometimes the focus is on the notes of the day before, sometimes on the program for the day or for the week to come, sometimes on issues of problem behavior as they have been coming up and on what is to be done about them, and sometimes on projects that everyone is involved in (Christmas decorating, an Easter pageant, a unit toy-making project for poor

kids, and so forth).

Certain settings seek to minimize group interaction among patients by binding the youngster so tightly to the staff members on his therapeutic team that these persons become far more important to him than his peers. Other centers take the opposite tack and carefully structure milieu groups that are addressed as such and that become vital elements in the management of behavioral difficulties. Thus, in the extreme case, all responsibility for acting-up is viewed as a group responsibility, and the group is restricted if one youngster acts out. As a result, the grouping tendency is brought into the service of the therapeutic enterprise and becomes an important factor in the creation of the treatment milieu. Indeed, one way of conceptualizing residential treatment is to view it as the long-range interaction of a staff group and a patient group within a common life space.

Administration

There are three facets to the actual running of residential treatment that need special emphasis. These are: role clarity, collaboration, and accountability.

Role Clarity Role clarity means that everyone in the setting has a pretty good idea of what his job is and how it fits into the overall mission of the setting. Role clarity begins with a written job description, but it scarcely ends

there. The role of chief child-care worker may be written down ever so precisely, but it still says very little about the fact that the particular incumbent sees himself as the primary therapist and may feel that he and his child-care group should keep certain aspects of unit life secret and not tell the psychiatrists or caseworkers about them. Thus there are official roles and then a universe of emergent, unrecorded, but functionally crucial conceptions about what people do that crystallize out of the interactions of ongoing therapeutic life. Authority may be formally assigned one way, but power may lie very much elsewhere. The matter of role is thus not an assigned and stable function alone; it is a dynamic entity that ebbs and flows and that must forever be worked at.

Nonetheless it is important to have clear initial formulations, so that there are no built-in structural impediments that would tend to make role clarity impossible. For example, questions of who can formally impose a restriction on a child and who cannot, who can conduct a group meeting and who cannot, who has access to petty cash for incidental purchases and who does not, whose responsibility it is to see that patients get to needed services or to recreational activities and who is not responsible for this, and so on—such questions often become sticking points and need definition.

Collaboration

But it is also clear that no amount of effort can or indeed should define everything, and we thus arrive at the next major administrative element: collaboration (Alt, 1960; Mayer, 1971; Trieschman, 1969). This is the heart of residential work. It is the process by which people from different backgrounds, bearing different responsibilities, and working out of different orientations get together and interact cooperatively to accomplish a common mission—to help the children. It sounds complicated, and it is; but it is also indispensable. It is important enough to require respect as a modality all of its own. Residential settings have to plan precious staff time on a regular basis for team collaboration. They must set aside and protect the occasions when the parent worker, the child care worker, the individual and/or group therapist, and the teacher all get together to do the critical task of communicating, exchanging, sharing, and planning for their patient and/or group. Their work is to pool their observations in order to arrive at a better understanding of the child, and to regulate their activities and build further programs on the basis of this shared insight. It can safely be predicted that there will be times when collaborators will disagree or will resent and criticize one another, to the point that collaboration breaks down and people stop working together. This in turn becomes a treatment crisis. It means that a consultant or a referee of some sort must sit down with this team and work with them, not on the problems of the child but on the issues in their collaboration. For unless these are resolved or at least partially detoxified,

there will be a series of mixed messages and double binds that get through to the child and the family, and treatment will fail. It is at the point of collaboration that the integrative, interactive process that is residential treatment finds its purest expression. The facilitation or the inhibition of treatment that follows is a specific function of how well this process is handled. It is here, in fact, that the covert roles referred to above find their fullest realization, and the informal power structure of the entire setting will appear here in specially pure form.

Accountability

The third administrative element that is becoming ever more important is the matter of accountability. This usually takes the form of requiring that a treatment plan with specific goals be formulated for each patient. Then a series of regular reviews can be undertaken to see whether these goals have been achieved or are being achieved, and if not, to ask why not.

This seems like a simple and common-sense course of action, but in fact it is a hotly debated and highly uncertain procedure. For many professionals the nature of clinical work is to be open-ended and to deal with what the patient brings up, rather than what we wish him to bring up. A given youngster may be shy, withdrawn, and encopretic. The goals may take the form of making him more outgoing and getting him to stop soiling. In fact,

however, as the work with the child gets under way, he may develop new symptoms that weren't visible before. For example, he may start to play with fire and matches, he may develop some patterns of aggressive behavior toward staff or peers, or homosexual activity may come into view that wasn't previously described. In short, a whole new set of concerns may arise, so that goals may need to be reset. Meanwhile the child might continue the encopresis, refusing either to discuss or to change this. At this point he may look like he's gotten worse rather than better, but in fact the staff is simply getting to know him better and obtaining a fuller view of his problem. In one case the encopresis may be the first thing to clear up; in another it may be the last, and it may persist long after other symptomatic behavior has disappeared. In any case, one has to work with what is now workable.

With so uncertain, shifting, and changing an object for professional attention, the formulation of concrete goals and the assessment of where one is are by no means straightforward matters. Even to measure whether or not a child is more withdrawn or less withdrawn can be a subjective and variable issue with many degrees of imprecision. The tendency to avoid long-term or over-all goals and to concentrate on the immediate issues of defense and relationship, to let the work come as it must, and to take it step by step as it unfolds, is by no means an evasive or unfortunate attitude on the part of many settings. It has its profound justification within the nature of the clinical situation, just as the notion of clearly defined goals and measures finds its

rationale in the everyday commonsense world of making and doing. One must make choices, and either choice is fraught with dangers. To impose goals can distort the nature of clinical work and make the therapist work for the goal rather than for the patient's needs of the moment, while to fail to set goals allows for loose, amorphous, un-self-critical work whose value and validity cannot be examined. It seems clear that some compromise needs to emerge. A way will have to be found to formulate the degrees of possibility for particular children and to specify how best to realize these possibilities, and then to look at the situation periodically and see how well one has read the situation and how well the methods used have accomplished what was defined as necessary. At the same time, this formulation will need enough flexibility so that it does not inappropriately constrict or deform the emerging clinical pattern as one works with a child.

It is hard to accept and understand that much work with very sick children takes a long time, that a fair number of such youngsters may need to be in some kind of treatment all of their lives, and that a few of them will even need to be in institutions all of their lives (Balbernie, 1966; Bettelheim, 1967; Robinson, 1957). Where one deals with such problems, goal-setting and evaluation have a different quality than they do with less severe forms of pathology. There is a considerable difference between altering a life style and removing a symptom.

Parent Work

The usual parent worker is a psychiatric social worker. One of the commonplaces of residential treatment is that patients are sent to such settings in part because they can't tolerate home or in turn be endured there. Once in the center, however, the connection with home often becomes a critical reality that might form the focus of treatment for many months. The parents, for their part, often need more intensive clinical work around the fact of the placement than they would if the child lived at home and were treated as an outpatient. The phenomenon of having a child institutionalized is a radical confrontation for any family. It has profound repercussions in the areas of parental guilt ("It's me who is to blame and my child is paying the price"), narcissism ("I've failed as a parent, but so miserably!"), jealousy ("How can these strangers think they are as important to my child as I am"), rage ("Look at the kind of people my suffering sick child is being subjected to"), and shame ("All the world knows now that my child had to be put away"). As a result, dealing with the parents of these youngsters requires immense amounts of time, skill, and support. In many settings, the question of the "workability" of the parents is one of the critical factors in deciding for or against admission; in others, regular parental attendance at casework or treatment sessions is a requirement for accepting a child (Mayer, 1971). Some agencies see the resident child and his family together at the time of the parental visits, while others have casework for the parents quite apart from

the treatment of the children. A number of settings view groups of families as treatment units. Sometimes these multifamily groups parallel the group structures for the children in the milieu.

Settings that take children from far away often have to dispense with close direct parent work, but they might recommend or require that the parents obtain help in their local community. A few centers—a very few—prefer to take over the child's life completely, discourage much contact between child and parent, and ask the parent simply to keep out of the picture as much as possible (Bettelheim, 1950). The other extreme is to throw the major emphasis of treatment life on family therapy and to use the center as a catalyst and enabler for such therapy. In general it seems fair to say that residential treatment requires and must be prepared to cope with active family participation in the therapeutic process at some level.

School

One of the major differences between the life of the child and that of the adult is our culture's absolute emphasis on the centrality of school in the child's life. An adult may attend school; a child must. Moreover, the child has a range of developmental needs and areas for ego growth that are specifically addressed by the realities of school. These include such elements as sublimation, mastery, cognitive unfolding, and refining of methods of impulse

control; the widening of his range of identification possibilities; authority encounters with nonparent figures; peer relationships away from the enmeshments with siblings; and a chance to try his wings outside the home in a variety of ways that make for growth. When children have problems, these may take the form of school failure in any of many realms. The child may fail to learn in one particular area or in all areas. He may be unable to cope with peers and may either withdraw, stay in chronic trouble, or run away. He may have a variety of reactions to teachers, from ungovernable erotic wishes to equally intense, angry, provocative engagements. All sorts of blends of such problems may appear, or one area of difficulty may in turn beget others. Thus, a child with a learning problem may feel so different from and inadequate in comparison to his peers that his behavior may alter. He may be unwilling to go to school, daydream all the time he is there, or divert himself from the pain of failure by whispering, joking, or clowning or by teasing, annoying, or attacking other children.

Hence, when a child becomes sufficiently disturbed and is referred for residential care, a major means for achieving a good treatment result must be to try to find out how to help him succeed as a student. In the service of this goal, a host of special techniques have been evolved for specific learning problems, generalized learning inhibition, coping with behavioral difficulties in the classroom, working out teacher-student interactions, and addressing the entire issue of the child as problem student. So central are such concerns

to child mental health that, as we saw before, many settings direct the main thrust of their treatment along this axis. They call themselves schools, their patients are officially pupils, and the whole therapeutic structure is built around a central core of academic and scholastic services. Other settings emphasize the milieu and consider the school as a major component, but still as only one factor among many within the structure of the child's daily life. In a few settings school is viewed as relatively peripheral to the more immediate goal of delivering various forms of therapy. Indeed, these are settings that have no special school of their own and send their children to the adjacent public schools. (Needless to say, they can accept only those children who can fit into such a pattern; and in any case, the residence staff has to work quite intensively with the public school personnel.) On the other hand, quite a few residences arrange with the local public school system to approve the residence school as a special branch within the larger system. This helps both with finances and with scholastic credits. In general, it is safe to say that some form of special schooling is offered within most residential treatment centers and forms a vital sector for help, therapy, and the furtherance of growth.

Typically, such schooling is conducted with classes that may be as small as two and seldom larger than eight. Many children will need some special one-to-one tutoring as well. The school group often is a vital area for work with peer interactions and can be used as one way to structure a therapy group. When a child no longer needs full residential care, he may often

continue to attend the residence school after discharge. Contrariwise, a major advance while still in residence may be to start attending an outside public school every day. In the common situation where a day hospital or day care program exists side by side with residential treatment, the children in residence attend the same in-house school and sit in the same classrooms with the day students. It goes without saying, that the teacher is a vital link in the treatment chain and needs to be included as a full-fledged collaborator in the team that serves that child.

Personnel

There are a great variety of professionals and paraprofessionals who work in the area of residential treatment. Occupational therapists, recreation therapists, speech therapists, art and dance therapists, and many others may be found practicing their discipline within or serving as consultants with a given setting. However, five core disciplines that are the most consistently present need special enumeration: social work, psychology, psychiatry, education, and child care work. The last group is the newest on the scene and merits separate recognition.

With the development of residential care, there has been an increasing emphasis on the life space experience as a vital dimension of treatment. As a result, the need for skilled people to live with the youngsters and bear this

therapeutic responsibility has increased proportionately. The child care practitioner has been the object of a great deal of thought, study, and debate in the field. A profile is emerging that tends to look something like this: by and large, some post-high school education is considered essential. In some settings the requirement for employment is junior college preparation that lasts two years and that is tailored specifically for child care work. Other settings accept a baccalaureate as a minimum preparation and do most of their training on the job.

In general, the child care workers need to understand something about normal development, the meaning of disturbed behavior, and how to intervene in crisis situations. They have to master a variety of programming skills, and they require a good deal of back-up and support in order to cope with many emotional challenges and confrontations that are their daily fare with the disturbed children. Optimally, the senior mental health professionals on the staff should supervise the worker's life space interviews and, on occasion, join with him in conducting such exchanges with children in order to serve as a model and guide. One of the most difficult tasks facing the members of the group of life space practitioners is to grasp the nature of the work done by the other mental health professionals and to recognize both the limits and the extent of their own work in relation to that of their colleagues. When an adequate sense of role has been achieved and sureness and skill have been developed in the management of the children, the experienced

child care worker emerges as a professional of considerable accomplishment and a vital member of the residential team.

Discharge

The work involved in the discharge of a child reflects the general task of the residential treatment center. The time spent in residence is only one phase of the total therapeutic experience of a disturbed youngster. Typically, the child coming into residence will have had some outpatient care before admission. It is because he needs more than outpatient experience can give him or than he can obtain from day care that he enters residence. Presently, if things go well, he will show improvement. The residential phase of the therapy is not aimed at cure. It is instead intended to effect enough improvement so that the further therapy does not have to be performed in residence. As soon as this degree of positive change has taken place, the child's treatment can be continued in day care or with clinic visits. Hence the discharge process is designed to effect the continuation of therapy under different circumstances.

It is often difficult to know when a child is ready to return home, or when he is ready to leave so long as he does not have to return home. Sometimes an extended visit (a three- or six-week stay) at home can be tried in order to test whether both child and home are prepared for the changes in

each other and whether they can now establish a way of life with one another that will work. Often it is clear that the child cannot return to that home, and foster placement is attempted. If the foster home can be assigned months before the time of actual discharge, the youngster can begin to visit there, spend holidays with the foster parents, and develop a meaningful connection. In this way, he will be moving to a familiar setting when his time comes to leave. Some agencies have established halfway houses, or group homes run by professional staff, to help bridge the gap between residence and community. Many children can well profit from such an intermediate, semi-protected setting.

Like intake, discharge is not an act: it is a process. As we saw, it implies moving to another level of treatment rather than to termination. Dealing as it does with very sick children and very sick families, residential care is at best demanding and hazardous: a properly designed, fully worked through termination is as vital to its successful outcome as is every other stage of its approach to the needy child.

Concluding Remarks

The need for residential treatment is difficult to determine. It is often remarked that in any given population of children, such as a school system, somewhere between one child in ten and one child in twenty will need

psychiatric care. Of this troubled group, it may be conservatively estimated that one out of every ten children who need care would benefit by residential treatment. On the basis of this reasoning, a rule of thumb in projecting need would be: of any given body of children, one child in one hundred to two hundred needs some time in residence. Thus if we estimate that the current population of children and adolescents is something like one third of the nation's people (one third of 210 million, or 70 million), then our need for residential beds is in the neighborhood of 350,000 to 700,000. Currently we probably have less than 10,000 in all fifty states.

Such figures are soft at best. The criteria for admission to residential care are not sufficiently precise to allow for exact estimates, nor do we know how many residential treatment centers there are, or how many beds they represent. In a way, it scarcely matters. The disparity between available services and even a wildly different estimate of need (say one tenth of these figures) still leaves an enormous gulf between what is necessary and what is available. In this connection it is important to recall that buildings can be provided quickly, but a pool of skills grows only slowly.

Bibliography

Aichorn, A. *Wayward Youth.* New York: Viking, 1935.

Alt, H. *Residential Treatment for the Disturbed Child.* New York: International Universities Press, 1960.

Balbernie, R. *Residential Work with Children.* Oxford: Pergamon, 1966.

Bettelheim, B. *Love Is Not Enough.* New York: Free Press, 1950.

----. *The Empty Fortress.* New York: Free Press, 1967.

Easson, W. M. *The Severely Disturbed Adolescent.* New York: International Universities Press, 1969.

Ekstein, R. *Children of Time and Space, of Action and Impulse.* New York: Appleton-Century-Crofts, 1966.

Foster, G. W., K. D. Vander Ven, E. R. Kromer et al. *Child Care Work with Emotionally Disturbed Children.* Pittsburgh: University of Pittsburgh Press, 1972.

Holmes, D. J. *The Adolescent Psychotherapy.* Boston: Little, Brown, 1964.

Konopka, G. *The Adolescent Girl in Conflict.* Englewood Cliffs, N.J.: Prentice-Hall, 1966.

Mayer, M. F. and A. Blum. *Healing through Living.* Springfield, Ill.: Charles C. Thomas, 1971.

Redl, F. and D. Wineman. *The Aggressive Child.* Glencoe, Ill.: Free Press, 1957.

Robinson, J. F., ed. *Psychiatric Inpatient Treatment of Children.* Washington: Am. Psychiatric Assoc., 1957.

Trieschman, A. E., J. K. Whitaker, and C. K. Brendtro. *The Other Twenty-Three Hours.* Chicago: Aldine, 1969