# Contextual Residential Treatment

## ABOUT THE AUTHOR

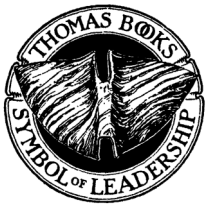
Don Pazaratz, Ed.D., R. Psych., has worked since 1970 with emotionally-behaviorally disturbed and disordered children and adolescents as well as mentally ill adults in residential treatment. He has worked within both the U.S.A. and Canada, and is especially fond of his work with Inuit in the Arctic. He has published forty articles in peer-reviewed journals as well as a recent textbook, *Residential Treatment of Emotionally Disturbed Adolescents: Principles and Practices.* Doctor Pazaratz passed away unexpectedly on January 28, 2013, just after submitting his manuscript for publication.

# Contextual Residential Treatment

## Dialectical and Behavioral Interventions with Adolescents

*By*

**Don Pazaratz, Ed.D., R. Psych**

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*For my déca*
*David and Erin*

# PREFACE

This book is written for all mental health clinicians, allied professionals, line staff, social workers, and students whose focus is on the adolescent in residential treatment and the problems facing the aging-out young adult and his transition to independence. It will be of interest to researchers, practitioners, educators, and policymakers who seek to refine their skills and knowledge of residential treatment and to learn specifically about contextual practice. There is an emphasis on eclecticism, treatment diagnosis, intervention strategies, counseling techniques, and staff training, with particular attention to developing cultural competency of treatment staff. Contextual practice as a youth care philosophy recognizes that the actions of peers, availability of role models, accessibility to institutions, and the like influence the behaviors of children and adolescents (Jencks & Mayer, 1990). As a treatment paradigm, contextual practice can be incorporated into any milieu or environment no matter the clinical orientation, level of staffs experience, or type and severity of pathology of the residential population. By integrating diverse theoretical and technical positions, a more comprehensive residential program can be realized because treatment practices, whether in-patient or otherwise, proceed from a similar framework toward the same goals. With an emphasis on stimulating developmental growth, contextual residential treatment of adolescents is founded on certain core principles, all of which are essential practices by front line staff: (a) stabilizing youth (both their symptoms and behaviors) so they become receptive to deconstruction of issues and feelings, (b) being empathic to build trust and connection that is fundamental to dialogue and insight, and (c) conveying respect and affirmation, which allows for interpretation, relevance, and understanding. Ultimately, the change process will result for youth placed in any form of treatment and care, when autonomy and self-reflective capabilities are internalized and acted on.

I wish to acknowledge the contributions made to my research and writing of this book by my colleagues and friends: Todd Humphreys, Rose-Marie LaCusta, Dr. William Morton, Dr. Ivery Daniels, Davi Rosario-Gadson, Connie Spencer, D. L. Jones, Teresa and Tom Crilly, Brian Hatcher, Karen Hedges, and James Mercer, with special gratitude to Norman Murray.

For the sake of brevity, the pronouns designating gender such as “she” or “he” will be used alternately in each chapter, beginning with the feminine form in the Preamble of this text.

D.P.

# PREAMBLE

Contextual residential treatment is based on how theory informs intervention, or the way in which clinicians formulate an adolescent's problems, shaping their ideas of effecting, motivating, and sustaining change in the youngster's life. Contextual therapy offers an important new direction in its application to residential treatment, youth care, and social work with emotionally disturbed adolescents and their families. In the contextual model, a focus is maintained on the individual while balancing a consideration of the social system or the physical and symbolic limits imposed by the treatment facility. Contextual practice addresses why adolescents who need out-of-home placements in residential treatment facilities have not formed a meaningful identity as they emerge into adolescence, how this lack of maturation and differentiation affects them developmentally, and why they are unable to deal effectively with the conflicts that arise between self-strivings and responsibility to others. This book provides a comprehensive overview of contextual practice that details an explicit theoretical basis for understanding the process that brings about change. It is also concerned with how the youth is understood contextually during the treatment process (i.e., patterns of behavior in family relationships, with peers, academically, and in terms of identity). In providing a description of the philosophy and nature of contextual residential treatment, it is hoped that the reader will comprehend how the youth's treatment needs are met during interactions with youth workers, social workers, special education teachers, consultants, and the like.

Briefly, the purpose of residential treatment is to create a safe and stable environment in which youngsters can learn to think differently about themselves and others, and to move toward greater harmony and balance in all relationships (Pazaratz, 2009). There are various therapeutic models that are enacted in residential treatment facilities. Some of the more mainstream theories of communal care and treatment will be referenced herein. Because teenagers typically express themselves through physical actions, all group care facilities have a behavioral basis. Some have an overlay of cognitive approaches, while others employ a synthesis of techniques to expand the scope and versatility of their model. In contextual practice, treatment staff focus on the youth's ideas and feelings, the nature of identity, cultural background, the basis of attachment to others, and why maladaptive relationship cycles get repeated despite their destructive nature. But the essence of contextual residential treatment is to help youth understand their behaviors as being affected by their environment or how they interpret it as a causality, to recognize their strengths, and to be

aware of their positive efforts and goals, rather than to ruminate about negatives or lost opportunities (Goldenthal, 1996). In the contextual approach, treatment staff are attuned to each youth's past injuries and present difficulties, as well as her potential. This emphasis on understanding the youth, as "being-in-the-world," according to Rogers (1986), becomes a catalyst for further change. Thus, during daily interactions, staff members concentrate on a youngster's uniqueness and her potential in order to stimulate future growth, both of which help the youth to overcome the pathology that exists in individuals and occurs in families. Treatment staff also look for ways in which youth can become self-aware. It is theorized that this enhanced insight occurs by exposing youth to dialectics that can lead to new decisions, alter attitudes, and consolidate adaptive changes.

Contextual residential treatment is enacted by front line staff utilizing a relational and individual approach so that therapy occurs in the context of their technique and not in terms of what they would say or do in dealing with emotional issues or confronting resistance and so forth. Contextual practice avoids dehumanizing techniques that result from simplistic understanding of adolescents and their families. It requires treatment staff to think about youngsters and their families in the context of interactions rather than focusing on their deficits. It recognizes that all behaviors are purposive so that the youth is not a set of problems or actions, but her behaviors provide information on how she exists in the world, where she is in the moment, and what she is moving toward. It considers the number of persons who function in the system of care and the impact of the therapeutic effort. It also recognizes that the environment elicits behavior and reinforces it. Thus, during placement, treatment staff never blame youngsters for displaying emotional problems, being different, having unique needs and individual preferences, or being unable to express themselves coherently. Instead, front line staff inculcate the concepts of trust and fairness, focus on strengths rather than pathology, and enhance relationships by ensuring respect for the rights of the individual. Fairness issues dictate treatment staff's actions throughout residential placement from the assessment phase to termination and discharge. It is postulated that the lack of enacting fairness in close relationships leads to conflict (Goldenthal, 1996). But fairness as an expectation between individuals is not easy to establish or to agree on what creates a fair relationship. Nevertheless, during conflicts, youth are encouraged to advocate for fairness or reciprocity by stating what they want, what they are prepared to give, but also to hear the other side. Fairness is an essential value within functional interactions and provides the foundation for the nature of the worker–youth relationship (trust). Fairness guides treatment staff's understanding of the youth's behaviour and helps workers to think about what may have caused problems and which intervention is the best practice. Ensuring fairness is the process for integrating youth into treatment

and an eventual transition home or to independence. Fairness as a practice is essential for developing the staff–youth treatment alliance and cooperative group interactions, implementing positive discipline, interpreting historical issues, enacting cultural competency, dealing with treatment resistance, and engaging families.

A central tenant of contextual residential treatment is that behaviors have a self-directed quality and can be evaluated or understood in the context within which these occur. Therefore, the emphasis of treatment is to create a functional environment by stabilizing behaviors and regulating social interactions that transpire between youth. To this end, treatment staff focus on how youth organize themselves emotionally and what skills they need for interacting with others in a socially acceptable manner or until they become self-regulating. Because all youth are in fact part of various social systems, it would be inaccurate for any of their behaviours to be interpreted independently of context because interactions with others or in the environment affect and modify the youth's response to others (Jencks & Mayer, 1998). A contextually focused residential treatment program emphasizes the importance of a youngster's family, using the community as a resource, and understanding the nature of cultural influences on the youngster that are transmitted by her family. These social arrangements are important in responding to the youth as an individual and can become assets for youngsters during placement, especially when youngsters are helped to reconnect with the part of their lives that provides relevance. But contextual therapy is not about telling youngsters and their families how to manage their lives. Instead, treatment staff want to help families to see alternatives to their problems so they can make their own decisions from a more informed position. Contextual therapy includes helping the family to balance the needs of children with the desires of their parents (Boszormenyi-Nagy, 1987). Contextual therapy follows a systems-oriented approach. During interventions, front line staff focus on dialectics or resolving contradictions because emotionally disturbed children and adolescents, whether in residential placement or residing in foster care, live and function in a material and social system that can and often does result in conflict.

Contextual residential treatment as a model seeks to include the total range of persons who are potentially affected by the therapeutic effort, such as parents, siblings, grandparents, extended family, and so on, recognizing that positive family functioning can be realized with the participation of all family members, including those who have left the family home, because they can provide information about the family (Jencks & Mayer, 1998). As a relational and individual approach, contextual therapy emphasizes the importance of empathy, communicative structures and equanimity, and ethical concerns regarding the impact of a therapeutic effort (Boszormenyi-Nagy, 1987). As a theory, it recognizes that it is not always effective under all circumstances,

therefore it will incorporate other techniques, which in effect allow it to be considered integrative. Inherent in its eclectic method is a conceptual schema that includes many significant aspects of other techniques (systemic, intergenerational, etc.) and theories (existentialism, humanism, etc.). It is consistent with client-centered therapy (Rogers, 1951), which states that there are only three necessary and sufficient conditions for personality change: empathy, unconditional respect, and congruence or genuiness. It is also founded on an overarching cognitive framework that seeks each person's point of view (Boszormenyi-Nagy, 1985). Contextual residential treatment as a theory is consistant with sociotherapy, considered a "school" for living and learning with its attention on the nature of connectedness and reciprocity. It also subscribes to and incorporates the myriad of ways that milieu therapy is planfully used in the treatment process (Filstead & Rossi, 1973). As a system of care, whereby the social structure is organized, contextual residential treatment benefits all persons interacting together as well as prompting change within the system of care. It is also multidirected and has a similar framework and focus as multisystemic therapy, a family-centered individualized intervention that targets the multiple systems in which youth are embedded (Huey & Henggeler, 2001). Ultimately, contextual residential treatment is concerned with the youth's personal growth, which according to Perls (1969) is the acquisition of maturity or a transcendence from environmental support to self-support. But its method is standardized and prescriptive so that staff responsibility, accountability, and trustworthiness are core treatment and care practices.

# INTRODUCTION

Residential treatment of disturbed and disordered adolescents is enacted in a social context and operates utilizing various psychological tenants. It offers a host of clinical services to families in disarray and in danger of disintegration, such as an opportunity for a period of relief and readjustment, modification of attitudes, planning together, and considerations of alternatives. While there are a number of residential models, this book elucidates on the principles and practices of contextual residential treatment. As a structural therapy and modality, contextual residential treatment unifies social learning, family systems, dynamic reconstructionism, cognitive-behavioral theory, group process, and pharmacological therapies. In practice, contextual therapy is interested in determining the reciprocal effect that the youth and the treatment environment have on each other and how the background or ethnicity of staff and residents combine to enact the milieu's culture that affects interactions. It is also interested in determining how the youth's family creates interactional problems or how the family is impacted by stressors and frustrations that reach across generations (Jencks & Mayer, 1998). It focuses on conceptual clinical foundations and treatment applications, in terms of issues rooted in a youth's past and kept alive by current interactions.

This book elucidates on the fundamentals of assessment, clinical descriptions of theoretical constructs, and application of technique. All of these domains are regarded as areas of interest and concern for front line staff during their supervision and monitoring of adolescents. This book also addresses the role of the social worker during interventions with families and while conducting group work. The book reviews guidelines for treatment staff that will enable them to assess a youth's overall development, regression, self-esteem, and sense of self. Assessments of youngsters include a description of developmental maturation, the level of stability or self-control, and the type of support or structure needed to enhance the youth's life. To comprehend a youngster behaviorally, treatment staff seek to understand the youth's social experiences that led to placement. A critical tenant of the contextual model is to avoid the dehumanizing effects of psychologically based techniques that are overly clinical or, conversely, not to approach the youth and his family with a too simplistic understanding and/or by way of blaming. Contextual theory also cautions that some intervention techniques can be problematic when used to justify adult behaviours (Boszormenyi-Nagy, 1987), especially those that dehumanize or institutionalize children and adolescents or are used as excuses not to provide adolescents with essential residential services because these are

too costly relative to foster care, semi-independence, kinship care, or community counseling.

Various clinical practices help to stabilize the disturbing behaviors of youth placed in residential group care. These techniques are described and discussed. Of importance in residential programming is the creation of structure and safety (Polsky & Berger, 2003) so that individual youth do not become overbearing or too fearful when participating with others. Residential staff must be able to make relevant observations of a youngster's reality testing or his behaviors in the residence, at school, in the community, and during contacts with his family, peers, and authority figures (Pazaratz, 2000). Developmental attainment is integral to understanding the youth's strengths, which must be stressed in order for him to overcome his weakness. There is an emphasis on the role of direct care staff and the way in which the worker evaluates and responds to the youth's progress or lack thereof, and the youth's self-view or sense of self. There is also the need for the youth to be carefully monitored because of his inability to self-regulate and to interact appropriately in group situations or within social relationships (Colman & Widom, 2004). When a disparate population of disturbed children or adolescents, who function at different developmental stages and behavioral levels, are grouped together, there is the potential for an increase of at-risk behaviors or group contagion (Rowe & Rogers, 1991). But it is the staff–youth relationship that helps the youth to adjust within the social environment and is especially critical for treatment adherence and to offset negative peer pressure. The complexity of establishing a therapeutic relationship and the worker's responsibilities are reviewed, as are dialectic and behavioral interventions. Standardized approaches to treatment and programming provide the consistency necessary to develop group harmony (Pazaratz, Randall, Spekkens, Lazor, & Morton, 2000), and these are summarized.

Residential treatment can be initiated as a result of an emergency placement or for crisis management. It can be short term (as especially favored in managed care) or long term for youth who are deemed at risk to themselves and/or others (Lyons & Schaefer, 2000) and those who are adjudicated to treatment. Residential treatment includes the behavioral management of decompensation, suicide ideation or attempt, and family counseling (Kagan, 1996). Some residential facilities offer after-care counseling and semi-independent living programs for aging-out youth (see Chapter 6), as well as remedial education, job skills acquisition, and life skills training. Residential treatment can be difficult and challenging for front line staff because severely disordered children and adolescents ignore boundaries, disobey rules, violate social decorum, and often overreact or withdraw excessively when corrected by an adult. Their mood swings can be especially unpredictable. For example, during social activities or community outings, even though residents have experienced a fun sense of

adventure, playfulness, and warmth, they can also digress rapidly into sullen brooding or extreme hostility over a perceived slight or an inadvertent comment. Sometimes front line staff will present themselves as didactic in order to teach coping and communication skills. But the overall staff's focus is to stabilize the disturbing aspects of youngsters and assist them to overcome hurt and pain that is manifest as alienation, social isolation, and often severe academic difficulties, if not failures (Ariel, 1997), and to maximize their potential to lead a productive and self-fulfilling life.

Stabilizing a youngster emotionally occurs by focusing on the youth's self-efficacy, personal control, and adaptive coping strategies (Laursen, 2000). In this effort, the youth's attribution of cause and responsibility for difficulties and problems is assessed as is the nature of his reaction to stress. Preplacement assessments establish whether the youth meets the admission criteria, which then becomes the basis of the treatment plan, from which individual programming evolves. The treatment plan is implemented through contracting and targets acquisition of skills identified as lacking or the foundation of the referral problems (Johnson, Rasbury, & Siegel, 1997). Staff members infuse developmental tasks within each youth's program and treatment plan that aim to strengthen the youth's sense of self and social skills. This includes teaching self-control in order for youth to moderate destructive, hyperactive, and impulsive behaviors. Direct care staff also counsel the overcontrolled behaviors or internalized disorders such as anxiety, depression, phobia, low self-esteem, and lethargy, all of which are factors related to identity issues and interfere with social adjustment. In essence, to overcome any range of interpersonal and intrapsychic difficulties, the youth's problem-solving skills and self-determination must be developed. This occurs when the social system is all encompassing, and front line staff provide youth with relevant information in the areas of communication, values clarification, decision making, and social relationships (Bertolino & Thompson, 1999). Change is thus experienced in behavioral terms with the young person achieving social competency, improved cognitive ability, and harmonizing his emotions and life patterns so that these are productive (Linehan, 1993). Residents are also assisted to coordinate their personal data (biography or background) and to realize its meaning or impact, which helps them to deal with their problems and provides a direction for treatment.

The central developmental tasks or psychosocial issues during adolescence include individuation, autonomy, trust, intimacy, and identity formation (Erikson, 1968). Most teens in treatment have had difficulty with these developmental issues. Controlling their choices is essential in order to maintain structure and cooperation in the residence, and for helping them to navigate a host of complex psychosocial issues. Upon admission to any form of placement, typically the resident's choices are limited until he demonstrates the

ability to make responsible decisions. Not only must the residential treatment process stabilize the youngster's symptoms (i.e., ADHD, depression, etc.), but it must also assist him to comprehend where and how he fits in developmentally or to understand those behaviors and attitudes that are age and phase appropriate. Without this awareness, youngsters in placement will not overcome the blocks that have impeded their growth and prevented their successful navigation of this developmental stage (Schaefer & Swanson, 1993). Prior to admission to treatment, most youngsters have been assessed. Assessment of emotional disorders is complex. Multiple methods of data collection in various situations from several observers are informative because a youth's behavior will likely change in different settings. Many youth in residential care meet diagnostic criteria for a range of disorders (Angold, Costello, & Erkanli, 1999). Assessments identify a youth's problems and developmental level relative to normative functioning. Assessments also seek to provide information on the young person's strengths, needs, and goals and the nature of family relationships (Sattler, 1988). Assessments by necessity are multidimensional when establishing a diagnosis as they examine relevant data (i.e., genetic, personality, intelligence, temperament, adaptability, etc.). Subsequent to placement, some assessments need to be updated because they may not provide current or sufficient information for treatment planning and intervention. Of concern is the way in which the social system affects the youth, such as whether and how the treatment philosophy or interactions within the program have created any abnormal behavior or exacerbated any existing aberrant behavior. Understanding of behaviors or causal factors provides residential staff with critical information needed to support the interests of all residents while protecting individual vulnerabilities. Evaluating youth prior to placement and subsequent to admission helps in determining whether residential placement is the least intrusive form of intervention and fulfills the criteria of a best practice (Anglin, 2004).

Residential treatment includes various phases. However, the most common problem faced by treatment staff is that not all youth go through these phases. Some youth can be resistant, uncooperative, defiant, and aggressive and even find it difficult to look within themselves and be open with others. Other youngsters cannot understand what makes a relationship good, whereas others cannot recognize a poor relationship and how it can be destructive. They have never experienced intimacy, feeling connected, or the support of parents. They have been made to feel unwanted. Understanding of the self and others is not an easy task for them. As a process, self-understanding is either conscious (through introspection, mindfulness, or awareness) and can be verbalized or is not conscious and cannot be verbalized. For these youth, it has taken a long time to develop insight and to become intuitive or it has never developed. Much of what occurs within a social system, such as a

family or residential facility, can be beyond the youth's level of awareness. Therefore, children and adolescents in treatment especially need staff members' help in accessing unconscious material and abstract constructions of interpersonal dynamics. Because behavior is influenced by the context in which it occurs, residential staff must understand this dynamic as well as to identify variables that predict and maintain it. Comprehension of a youth and the etiology of his problems advances the possibility of a successful staff–youth connection, increases the probability of the youth's stabilization, and decreases the number of ineffective interventions. Resolving behavioral issues enables front line staff to set attainable treatment goals and determine the most efficacious technique to stimulate, monitor, and maintain change. In this respect, the psychosocial assessment can be instrumental for evaluating and updating the youth's adjustment to placement. It is a practical clinical instrument completed by direct care workers, who seek to explain the way in which a resident views and interacts with his environment, the types of controls that are effective, the nature of the resident's defense system, stress tolerance, reality testing, adequacy of psychological resources (resiliency), and self-concept. By assigning the task of writing the psychosocial assessment to direct care staff, it will likely result in a more realistic evaluation as well as ensure greater staff adherence to its complementation (Horner, Sugai, Todd, & Lewis-Palmer, 2000).

The role of direct care staff is varied and complex. It includes relationship building, goal setting, and intervention planning. Sometimes front line staff may have to force residents to do things they do not want to do. This may include keeping residents from doing those things that they should not do. Both interventions are to be enacted without undue pressure, coercion, or physical force. Yet too much discussion, justification, or explanation by front line staff may reinforce the oppositional youth's defiance (Pazaratz, 2003). Residents especially need to develop skills that promote cooperation, such as deciphering of mixed signals, understanding other people's motives, respecting boundaries, following instructions, utilizing foresightedness, and being able to set short- and long-term goals. Ultimately, living concordantly with others requires the utilization of negotiation skills and the realization that conflict resolution is not always easy nor is getting one's own way always possible, realistic, or necessary (Durrant, 1993). Direct care staff help residents to acquire frustration tolerance, develop friendships, deal with school pressures, respond to positive peer pressure, and follow program expectations. These critical adjustments cannot be realized especially if the worker and youth are always in conflict or fighting one another for control. To minimize the likelihood of conflict, staff members define and enact their role as benign caregivers. While some youngsters will cooperate with staff, many will give into negative peer pressure, and others will avoid dealing with reality or any intense negative feeling. Some youngsters will deny having problems. They have few needs!

They make no demands and cannot open up or connect emotionally with adults. To avoid conflict or gain validation, youth will tell staff any kind of story or what staff want to hear. In fact some youth get along with staff but "act out" when their peers "act out." They follow the leader and can be easily manipulated by a higher functioning or higher status youth. When their transactions are repetitive, they reveal how and why they are stuck in their behaviors, and, likewise, a direction or rationale for bringing about change often emerges (Kernberg, 1984). Thus, front line staff need to recognize both overt and surreptitious behaviors in order to deal with the mutually influencing actions and sequential interactions that can become problematic.

Many youth in treatment expect workers to compensate them for a lifetime of depravation. They have been neglected or abandoned by their family or caregivers. Others come from a family where their parents have been too intrusive, controlling, demanding, and domineering, and they may have also expected the social service system to look after them. Still others come from homes where there is little interaction with adults, often no intimacy, and family members go their own way with little regard for each other. Thus, many children and adolescents in treatment have not developed a congruent identity or an integrated sense of self. In effect, the youth has become a person without an identity. In fact, the youth may have tolerated abuse in order to fit into any setting available or to get along (survive) within a social group. Consequently, the youth has become directionless and, out of necessity, superficial. Yet there are also the aggressive and defiant youngsters who have made noncompliance a way of life. They are emotionally volatile. They will not open up! They will not talk about things that really matter (Kagan, 1996). At times, youth workers may feel overwhelmed by the multiplicity of tasks and different personalities they encounter daily. Maintaining self-control and not acting on feelings that have been triggered by any one youngster, the group of youth, or conditions, is a fundamental and necessary youth worker skill (Kiraly, 2003). This book discusses how treatment staff can remain emotionally available for the needs of residents, as well as understand the ways in which they can deal judiciously with residents who try to circumvent, con, play workers off each other, and even attempt to seduce or manipulate the worker. Knowledge of healthy development and age-appropriate behaviors is essential in order to identify and redirect problematic behaviors, but also to discern normal manifestations of childhood or adolescent playfulness and exploration. This awareness and distinction is also reviewed, as is the worker's interactions within a team structure.

How do youth workers translate the theory of residential treatment into daily practice? Briefly, residential treatment and care is based on certain conceptual frameworks such as learning theory, behavior therapy, group theory, milieu therapy, integrative theory, and the like. Applying concepts and ideas

that evolved from evidence-based practices helps workers to organize themselves and the milieu, and to implement the daily schedule that comprises the routines of chores, activities, meals, and counseling. The youth worker's role includes providing residents with recreational experiences, community activities, reinforcements, corrective information, and creative opportunities. Youngsters are stabilized and integrated into treatment when youth workers create and follow a structured schedule. But the effective youth worker does not enact his role based on giving consequences, create dependent youngsters, make treatment a drudgery or oppressive, ignore team members and their efforts, or blame others (such as parents, supervisors, etc.), for daily frustrations. Instead, the worker integrates diverse intervention strategies into the resident's normal cycle of daily life, keeps a focus on the overall treatment plan, and remains abreast of best practices in youth work (Pazaratz, 2003). During interactions, residential staff use interpretation and empathic atunement and model authenticity and openness (Maier, 1987). Even though staff emphasize issues in the here and now, some youngsters remain withdrawn, do not talk, and are reluctant to acknowledge or express their feelings. Conversely, some youngsters are hyperactive, constantly anxious, and incessant talkers. Their insatiable need for attention and validation can be tedious, burdensome, and even overwhelming for both staff and peers. Ultimately, during placement most youth have difficulty maintaining self-control, are incapable of correcting their thinking errors, and repeat the same mistakes. For some residents, their defense mechanisms are too strong, whereas for others these are just ineffectual. Nevertheless, they mostly feel emotionally vulnerable or do not know what is wrong. So what can residential staff do to help residents deal with complex feelings and at times the overly structured social environment of group care? The worker approaches each youth as a unique individual, validating the youth's strengths and interests, teaching him to relax, to be mindful and reflective (McKay, Wood, & Brantley, 2007). This approach also requires understanding that not all youth will respond to staff efforts even though the workers presents themselves as caring and genuine. The youth worker also comprehends that some youngsters find it easier to express themselves indirectly through play, art, games, sport, or therapeutic activities (or movement), while others are more comfortable with and responsive to structure and formal counseling sessions. Flexibility is an essential and necessary youth worker skill.

In the following chapters, the reader will be introduced to the contextual residential treatment model that focuses on teaching youth to feel safe, to develop their potential, and to learn to deal with conflict. It is the actual social process within the milieu and the positive nature of social interactions that give meaning to the resident's experiences. During interactions with others and as the result of youth reflecting on these dynamics, there is the acquisition

of information and the development of competencies. But to determine what the youth is experiencing and how the youth uses information and personal resources, treatment staff observe the youngster, seek verbal feedback, and attempt to answer the following questions: What is the youth's current view of himself and others? What factors obstruct the change process? What are the youngster's defenses and against what? How does the youth use the milieu, staff, peers, and community as resources? How can the resident get significant others to react differently to him? It is important for residential staff to be aware of the effect that expectations within the environment and communication patterns have on youngsters. This means that staff members must learn to recognize how each youngster impacts the environment and its social system. This type of awareness brings an understanding of the resident's adjustment or lack thereof, which is affected by conflicting feelings of guilt and innocence, powerfulness and powerlessness, and attention seeking and needing solitude. In this regard, the reader will be shown how to approach the youth on his level of understanding and relating, and to recognize which youngsters have learned to survive by not talking. Finally, there is information on how to connect with withdrawn youth, to encourage them to risk in relationships, as well as to deal with their feelings.

This book is divided into ten chapters. Chapter 1 outlines the general parameters, methods, and rationale of residential treatment and the need for residential placement. Chapter 2 reviews the nature of the functional and dysfunctional family, and the impact of parenting styles on the developing child and the emerging adolescent. Chapter 3 describes the theory and method of the contextual residential treatment model. Chapter 4 expands on dialectical and behavioral intervention strategies that residential staff can and should utilize to stabilize and engage youngsters during different treatment stages. Chapter 5 discusses social work practice and the counseling role of the social worker throughout the treatment process. Chapter 6 is composed of three case studies of hard-to-serve aging-out older adolescents still in placement. Chapter 7 describes the highly resistant adolescent who uses drugs and/or other forms of acting out. Chapter 8 explores the special educational needs of youth with behavioral and cognitive problems, exhibited through externalizing and internalizing disorders. Chapter 9 highlights the importance of activities and groups and how these help to transform and redirect youth toward prosocial and proself behaviors. Chapter 10 integrates and summarizes the previous nine chapters. Some overlap among chapters exists, which is necessary thematically to flush out the details of the multidirectional features of contextual therapy.

# Contents

# Contextual Residential Treatment

Chapter 1

# Theoretical Considerations of Residential Treatment

## NATURE OF THE PROBLEM

The development of children's personalities occurs through interaction with others, in specific groups, such as their family, with peers, in the community, and the like. But the primary group that stimulates a child's maturation (i.e., physical, emotional, intellectual, and social development) are parents. In fact, parents largely shape the child's external environment. Parents and familial relationships provide for and are the context for a child's sense of safety and of self, as well as connection to others, adjustment, and life view (Bowlby, 1969). Children's growth and fulfillment of their psychological needs arise when parents embrace their child emotionally and create feelings of attachment and well-being. It is the affective experiences with parents, such as the need for specialness, idealization, empathy, and its mirroring functions, that profoundly impact the child's development of the self (Kohut, 1971). Family interactions are also the basis for character development by inculcating social and living skills, which provide the child with life long socialization experiences and attachments (Elkind, 2007). The nuclear family and the extended family offer role models that directly affect the child's sense of worth, belief system, and cultural values. Ultimately, children's personalities, self-concept, life plan, attitudes, morality, and value system are profoundly influenced by the nature and quality of their relationships within the family (Balk, 1995).

Adolescence, as a developmental phase or transition from childhood to adulthood, has been described by Erik Erikson (1983) as a time when character begins to form. During this period, there is a growth of thinking, contemplation of ideas and ideals, as well as a quest for social and sexual stimulation. Challenges seem to arise as a natural result of distinct intergenerational conflict or the normal differences evolving from assuming and aspiring to different roles and responsibilities. But if the course of childhood development is subject to trauma, then the youth's psychic structure will be unstable and unable to deal calmly with the issues that he will encounter as a teenager in these domains. Nevertheless, the developmental changes experienced during the teenage years can be stressful and compounded by a seeming lack of stability in family life and predictability in society as a whole. The family unit is in continuous flux or evolution, and relational dynamics may be confusing and often difficult for many adolescents as they simultaneously undergo enormous physical maturation. Teenagers experiencing developmental pressures can find it difficult, if not overwhelming, to balance their needs with those of other family members, peers and society and its institutions undergoing similar transformation (Balk, 1995). Adjustment difficulties in the emerging adolescent typically show up psychosocially (i.e., academically, socially, mentally, and behaviorally). Consequently, their difficulties or reactions to interpersonal stress and developmental pressures can completely overwhelm some parents, disrupting the orderliness and calmness of family life. Parents sometimes

add to their children's distress by purposefully depriving them (as punishment) of a sense of belonging, causing them to conclude that they are worthless (Dreikurs, 1968). Yet some youth will take advantage of the chaos that their family is undergoing and add to it.

Adolescence is not only a biologically defined life stage, it is also an ever evolving sociohistorical construction. In this respect, the adolescent has to anticipate and navigate social changes, as well as be able to understand and accept society's demands for prosocial behaviors. Resolving the divide between adult expectations and peer pressure, or conflicting social pressures, occurs when the youth overcomes personal difficulties while being able to show concern for the welfare of others (Adler, 1938). Yet some youth are obsessively attached to their immediate social world and overlook the possibility of involvement with others. The level of social interest reflects the youth's maturity or normativeness; if the youth's inferiority feelings are too great, then there will be poor social adjustment. When a youth truly feels socially connected as an equal, she will feel confident in herself and find a sense of purpose and meaning. When youth believe they belong, they become motivated to pursue goal-directed behaviors. As youngsters experience success, they enlarge their capacity for social interest, but they restrict it when they are defeated or discouraged. In spite of complex and profound social and family pressures, most teenagers are quite capable of balancing conflicting value systems (i.e., those of their parents with those of their peers) (Erikson, 1983). The typical adolescent is viewed as being able to predict, cope with, and resolve divergent issues or dilemmas (peer approval vs. adult expectations), and to pass through the various stages toward maturation and individuation with minimal difficulties. This does not mean that adolescents and their choices are always validated by their parents or do not result in peer conflict. But the majority of decisions that adolescents make are usually purposive or advantageous. They expect and rationally tolerate a certain degree of disapproval and understand that as a result of their preferences, there will be a sense of fulfillment and accomplishment and instances of disappointment or setbacks. Eventually most teenagers will ascribe to or enact a value system and a philosophy of life that is not too dissimilar from that of their parents' (Esman, 1972). As a member of a functional family system, the adolescent recognizes that if she strays too far from acceptable behaviors, as defined by rules and communication patterns, then there will be emotional responses or feedback from other family members that has the purpose of rectifying transgressions.

Thomas and Chess (1972) define healthy parenting as a temperamental fit between parents and their children. Healthy parenting is realized when children's emotional needs are satisfied, and their fears (insecurities) are soothed with affection. The parents convey that their children are valued not disparaged, indulged instead of diminished, responded to in the moment, and embraced within a home climate that is supportive not severe. The child is never isolated or made to feel helpless and hostile, and upon emerging into adolescence, the parent–child relationship remains meaningful. Because the adolescent does not feel valueless, there is not a need to find love as a solution to all problems (Wachtel, 2004) or to compensate by indulging in illicit substances and/or unhealthy relationships. The adolescent feels basic confidence, instead of anxiety, and does not have to deploy defenses to achieve safety. This view of meaningfulness of the parent-child relationship is consistent with Horney's (1939) position that healthy development in children is predicted on the authenticity of love, respect, guidance, and fair treatment. Close parental involvement and goal-directed admonition helps the child to develop inner strength, self-confidence, freedom to pursue the self, and courage to experience the self spontaneously, as having

both love for others and a healthy independence from others. Benign parenting enables the adolescent to attain a kind of maturity and is the basis for encouraging the youth to match her behaviors to the demands of the social environment. The mature adolescent has transformed from being dependent on her parents to experiencing satisfying peer relationships and developing ideals and ideas (an identity) that differ from childhood.

In order for the adolescent to find permanent love objects, the stabilization of character and the development of a sexual identity is especially necessary (Esman, 1972). Sexual identity is intricately connected to interpersonal and societal experiences that are forged within the same contexts as are the other aspects of identity. Sexual identity formed during the adolescent years influence self-care behaviors and attitudes, as well as the formation and refinement of other identities (e.g., gender, ethnic, academic, etc.), (Brooks-Gunn & Graber, 1999). According to Erickson's (1968) theory of psychosexual development, the successful resolution of a crisis during a developmental phase can predict success in future crises. This would mean that an unhealthy sense of sexual self during adolescence will impact almost all other domains of the youth's life, so that the consequences in adulthood might limit the capacity to form intimate relationships. In effect, because the youth has never internalized a healthy sexual identity necessary for stabilization of character, then she will experience difficulty relating to others. Without an intact sense of self or a normative identity, a deviant or dysocial self view could become the basis of role fixation or confusion and acting out. But for the adolescent emerging into adulthood with a confident or an integrated identity, she is seen to have the ability to accept herself and others and to engage in healthy or reciprocal relationships.

While childhood and adolescence are separated portions of the life course, for many teenagers who wind up in residential placement, this distinction between these life stages is missing due to developmental delays or regression and a lack of maturity (Pazaratz, 2009). The immature regressed adolescent typically comes from an unstable home, where her parents are overwhelmed by multiple problems, such as profound isolation and disconnection from extended familes and social relationships. The parents can be harsh, cold, distant, and inflexible, and they see their children as a burden and an obstacle to their well-being and that of the family's. When there is child abuse, this becomes a factor that impedes or stunts emotional development. Consequently, the child does not incorporate an emotional capacity and a value system that is necessary for dealing with self and other imposed expectations. This lack of early nurturing also has been cited as the basis of adjustment problems that hinder the youth forming meaningful relationships (Bleiberg, 2001). The youth lacks the ability to self-validate and exhibits undersocialized, immature, and needy behaviors. The youth feels overwhelmed by pressures or expectations, has difficulty differentiating the advantages of competing choices, misperceives other people's motives, suffers repeated failures, is overwhelmed by rejection or disappointment, and experiences an identity crisis. The youth regards herself as valueless, defective, and distressed, and because she is unable to reciprocate in relationships, love others, or feel empathy, she goes from one emotional crisis to the next (Kernberg, 1984). The youth's poor self-concept and self-downing becomes the central feature of her emotional problems (Ellis, 1994) and the reason no cohesive sense of self or direction for the self has emerged.

## EMOTIONAL DISTURBANCE

Kohut (1971) has identified a self-object construct, which refers to the experience all

people have in certain relationships, where the other person fills in for the self, providing certain essential psychological functions. Children internalize images of objects and continue to relate to them even after they have ceased to be present. These objects, such as people and things, are preserved symbolically and continue to influence the emerging adolescent's activities. The other person through empathy, a reflective function, creates a mirroring response that is sustaining and joyful, which then becomes the foundation of the child's ambitions or provides the child with a calming source of idealized strength, reassuring her with affirmation and a feeling of belonging. Self-object relations are the formative interpersonal context that either results in healthy development, with the child securing a facilitating attachment, or becomes the basis of disturbance because the parental connection is lacking. Kohut states that the inner drive in humans (libido) is more concerned with the establishment and maintenance of relationships or object seeking than pleasure seeking. The child's emotional linkage with the principle caretaker stimulates her capacity to love, engenders a sense of safety, and creates the basis for trust, all of which are the foundation for self-trust and self-care. During the crucial first three years, the primary mothering figure must care for and respond to her child and create an attachment bond (Sullivan, 1953). However, according to Bowlby (1969), if the parent and child do not feel connected, then a persecutory or paranoid attachment will form where basic trust should be (see Jenny case illustration in Chapter 6). Just as the mother must promote a compassionate attachment, she must also convey and lovingly support the child's individuation, or the process of the child becoming a separate and unique individual. Without unconditional parental validation or acceptance, it is unlikely that the youngster will ever feel secure and self-confident. The child will feel frustrated but continue to seek love and approval from indifferent parents. Gradually, the child will begin to feel detached and defective, and most probably experience difficulty adjusting to changes that occur during periods of enormous physical growth and emotional uncertainty (Kohut, 1977). Thus, when the normal development or emotional connection with significant others is delayed or impaired, emotional dissonance emerges in the youngster.

While clinicians such as Heinz Kohut (1971, 1977), who subscribe to the Object Relations Theory, believe that emotional maladjustment in children results primarily from the parenting and attachment style enacted in families, there are various other theories for the genesis of emotional disorders (Gullotta & Blau, 2008), which include genetic, environmental, and familial factors or a combination of them. Geneticists, for example, view disturbance as arising organically or from a biological base such as diagnosed in Autistic Spectrum Disorder (see Ken case study in Chapter 6) or other Pervasive Developmental Disorders, including Fetal Alcohol Syndrome (Gabriels & Hill, 2007). For Farrington (2004), emotional disorders can be understood from a psychodynamic perspective or by comprehending children in the context of their interactions and communications, meaning that the child with a cognitive delay becomes overly frustrated by environmental circumstances. Farrington's observations are supported by Gulotta and Blau (2008), who found compelling evidence that the cause or etiology of interpersonal and intrapersonal disturbances can be circular (i.e., the effects show up intrapsychically, as maladjustment, where additional social/personal difficulties or conflicts are precipitated). Yet Rutter (2003) believes that the exact etiology of emotional and behavioral disorders is not known but appears multifunctional in origin. However, Miller (1965) states that children experience adjustment problems when they