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## **Creative Thinking and Talking in Residential Care**

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### **ABSTRACT**

This paper describes an interdisciplinary discussion of a difficult child in residential care, as a case study for practicing creative thinking. While methods for problem solving in residential treatment are primarily guided by theoretical supposition, this paper offers a rationale for approaching treatment as a widely open exercise in creativity rather than the limiting reliance upon conventional but unexamined premises. Two applications are considered: the way care workers think (our assumptions) and the way we talk (the power of words at creating outcomes).

### *Introduction*

To visit the Andrus Children's Center is to step onto a campus that is at once more than just a place, but a realm, where even nature itself seems to have conspired with the agency's mission to be therapeutic. Nestled between the still wild forest reserves along the Hudson River valley of Hastings-on Hudson and Yonkers, New York, the experience of the Andrus Children's Center begins with a sharp turn into the driveway at 1156 North Broadway, but does not really end anywhere. Instead, it continues to unfold into a varied and rolling landscape of possibility and options.

The driveway begins narrowly and is immediately met with two roads that meet to form a perfect circle just in front of the welcoming Administration building, which aptly, is a beautiful house. The house, whose founders birthed and raised their own family there, stands fast in 75 years of "creating opportunities for the young." When you enter the campus – by foot or car, for the first time or repeatedly – you are always met with the sense of not knowing exactly which way to go or which way to look. This is a campus of options. The options unfold right before your eyes. The two roads on either side of the administrations building's front lead back to one another amid a delectable kaleidoscope of trees, hills, fields, amid old and new stones. Just when the eye catches what seems to be the end, something new pops out to lure and to expand an unexpected

journey toward physical excellence, where cottages, peach trees, and a pond come to form this Forest of Arden along the Hudson River Valley. Even before meeting one person, you cannot help but feel welcomed and safe. And then you see it. Just before you can come up with the right word to describe it, you see an adult or two – or maybe many children en route to or from a classroom or cottage – bouncing instead of walking, laughing instead of frowning, and looking directly at you.

As a serene background to a profession that works in the business of psychological trauma, the pervasive and warm sense of welcome typical at the Andrus Children's Center can be deceptively inviting: beneath the infectious kindness of the community, however, people still hurt here.

### *Difficult Behaviors in Residential Treatment*

Foundational to the work at Andrus, as with any residential treatment center for seriously emotionally disturbed children, is a recognition of the complex interplay between staff and client trauma and the effects that this has on judgment and performance overall. Rothschild (1993) explains what is behind the common stages of getting stuck when working with traumatized client populations: a complex system of transference and counter-transference.

She writes, "The goal of working with transference is the main goal of much of psychotherapy...separating the past from the present so that the ghosts and imprints of the past no longer interfere with life in the present freeing the individual to develop new and more effective resources and tools to further his life." (p. 1) Figuring things out, therefore, becomes tricky, requiring an extraordinary commitment from the entire therapeutic community to practice interdisciplinary collaboration with one another in order to create treatment breakthroughs for difficult clients. At Andrus, in true form to the wider reality of the profession, we sometimes find ourselves as uncertain and helpless as the very children for whom we toil. And just as active dialogue serves to unravel the complexities behind our work with our clients (Saari, 1991), it is also pivotal in getting care-workers to overcome difficult client behavior-patterns that so often beleaguer our attempts to treat them.

What to do in residential care when we find ourselves stuck in dealing with challenging behavior? The first thing we do is to talk to one another.

In late summer, 2004, the staff members of our oldest boys' cottage had reached a disturbing impasse with 9 year old resident Nicky.<sup>1</sup> For most of his 18 months at the agency, Nicky has exhibited challenging behavior. As a result, much of his day and evening routines occur under one-to-one staffing. Still, many of the Milieu Therapists have complained to one another about the near impossibility of working with this child – he does not listen, is defiant, and can display aggression without apparent warning or provocation. A growing sense of helplessness over working with Nicky intensified when he severely injured another resident's eye after throwing a rock during a moment of upset.

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<sup>1</sup> Child's identifying information has been altered to protect confidentiality.

The workers' response to this aggression comes from their commitment to the organizational and treatment model known as "Sanctuary" (Bloom 1997). According to her theories rested in the Sanctuary model, Bloom (2000) views any community violence as a sign of collective disturbance. She asserts, "...violence must be viewed as a symptom of a breakdown in the social order, not just a problem of the individual. Every act of violence must be analyzed as a problem of and for the entire community, including the use of seclusion, restraint, or any other form of coercive control." (p. 83)

### *Talking Through Assumptions: Key to Team Collaboration*

Therefore, in the spirit of collective responsibility an interdisciplinary group of Andrus workers called an ad hoc meeting to openly discuss ideas for working with such a difficult child as Nicky. A general staff email invited any direct care worker and administrator who might be interested in attending. As Training Director, I attended mostly out of curiosity to see how well people integrated the primary tenets of our basic behavior support curriculum, Therapeutic Crisis Intervention (TCI). Also in attendance were our residential director, assistant residential director, admissions director, social worker, school teachers, school teacher's assistants, recreation specialist, and 3 milieu therapists – all interested in positively shaping this young boy's life. I was impressed with the turnout, and confident that we would find a creative breakthrough somehow – for the boy, but also for ourselves. First we reviewed the facts.

On the day in question, Nicky, although staffed one-to-one, had joined about 6 other boys for games in the recreation center. When it was time to leave, Nicky did not want to go and was quite vocal about it. Perhaps as an attempt to coerce the child into leaving, one Milieu Therapist jokingly made a pejorative comment to the child. Picking up on that, the other boys teased Nicky. In reaction, Nicky picked up a rock, hurling it toward a peer, whose eye it struck, causing the child to require emergency medical treatment that would begin a slow period toward recovery.

The ad hoc group focused more on the overall effectiveness of treatment for Nicky than on the incident: the connection between the provocative statement of the staff member and the child's reactive aggression stood without dispute. It seemed clear that the unfortunate injury might have easily been avoided. Yet, the teachers and childcare workers agreed that in general this boy was a child with whom it was extraordinarily difficult to work. In general, he does not listen. He can be impulsive and violent. He refuses to stay in the classroom. He taunts and provokes peers. And he does not relate well to adults. Perhaps residential is not the right place for him.

"But please tell me what works for the boy," I began. "What does he like? What interests him? What turns him on? Without being able to answer these, I believe we have not really even started to know if residential can be the right place for him. We have to talk to the boy. When he is getting as stuck as he seems to be now, I think we must focus so much of our energy on talking...talk to him until we find what it is that really motivates this boy."

These questions opened a hearty debate about whether or not such an approach, which relies so heavily on building emotional rapport, could actually work with children whom we think to be genuinely anti-social. What if Nicky were anti-social? How should we talk, if at all, to an anti-social child? Had we as an agency really done all that we

could to treat this child? Would it continue to be impossible for this child to properly interact with other children in his classroom and cottage? Would he have to remain staffed in seclusion from his peers? These questions burned upon my heart as a sense of helplessness seemed to emanate from our attempt to figure things out. By the end of the meeting, we all agreed to stay committed to the child's treatment even if uncertainty still hovered about our various ideas.

At a certain point, I could not help but find it ironic that as we struggled to figure out how to connect with the boy or whether or not we could adequately reach past his difficult behaviors that he was nowhere near the discussion. As we spoke to one another as a treatment team, the subject himself was sitting with a childcare worker alone, away from the peers and classrooms that he so frequently upset. As training director, I had not yet personally met this child myself and, therefore, after the meeting decided to pay him a visit.

In a way I was nervous to see the child who might quite possibly be impossible to help. But ultimately, I was guided by the belief that if this 9 year old boy could talk and listen, we could make a connection. After all, much of the work that we do in all forms of psychotherapy and cognitive behavioral therapy amounts to a process of translating talk into treatment. (Forman, 1993) For a field that has mastered the art of talking, what then could be missing if not a most crucial component: creativity?

### *Creative Dialogue*

**Adult:** Hello. Nicky is your name, right?

**Child:** [nod]

**Adult:** May I introduce myself to you?

**Child:** [nod]

**Adult:** My name is Michael Thomas, what is your name?

**Child:** Nicky.

**Adult:** Nicky watch this. I'm going to show you how to shake hands. Here's what you do. When you're meeting someone and you're going to shake hands, you look him straight in the eyes; stand up straight, and with a firm and steady grip shake hands like this. [demonstrated]

**Child:** [smiles]

**Adult:** Now, let's do the whole thing. I'll introduce myself, you tell me your name, and we'll both shake hands in a proper way. And don't forget to stand straight and look me directly in the eye now, Nicky. And speak nice and loudly when you tell me your name! Here we go: Hello, my name is Michael Thomas. [extends hand]

**Child:** Hi, my name is Nicky. [shakes hands firmly]

**Adult:** Well done, Nicky! You are very good at that. Now you know how to properly and formally shake hands. I will expect you to remember to shake hands with me like this every time I see you, OK? You know, my mama taught me how to shake hands like this when I was a boy and I'm so glad to have remembered it now that I'm a man.

**Child:** [nods and smiles]

**Adult:** Now, let me ask you – do you like being in this room?

**Child:** No.

**Adult:** Why not? What it is like for you?

**Child:** I'm bored.

**Adult:** I believe you and I can see why: when I walked in you were just lying there on the couch. You didn't seem to be doing anything fun, having any conversations, reading anything! You don't have anything to read in here?

**Child:** No.

**Adult:** How old are you, Nicky?

**Child:** Nine.

**Adult:** Nine. You know what? Listen to me very well here, Nicky. The most important thing in the world for a nine year old boy is to read! I know that you struggle with a lot of your problems, Nicky, and you don't know what to do because you don't have the ideas in your head to figure some of them out. When you read, you will discover the great ideas that will help you figure out amazing solutions to your problems! Reading puts ideas in all of our heads. With those ideas we can create new ideas of our own.

Nicky, wouldn't you like to have new ideas that you come up with all on your own!?

**Child:** [attentively] Yes.

**Adult:** Fantastic! Reading will show you how! Reading puts ideas in your head. And with more ideas, you will have more choices. These ideas and choices will build your own imagination. And you'll be able to figure new things out for yourself. It's amazing isn't it! This is why reading is the most important thing for a nine year old boy—it helps you to help yourself!

**Child:** But I don't know how to read.

**Adult:** Ah, well then this is perfect! We now know what one of your most important jobs should be. Learning how to read should be your most important goal. Are you learning to read in school?

**Child:** Yes, I'm trying to.

**Adult:** Ah, you see – this is fantastic! One of the first ways that we all get our minds ready for reading is to be read to – and a lot! Let me suggest this to you: every time you get a chance, ask your staff members to read to you. By you listening a lot, this will get your mind ready and it will give you new ideas to for your own imagination. Have you thought about what kind of adult you'd like to grow up to be?

**Child:** No.

**Adult:** Reading opens up a whole new world for you that will make life, fun, powerful and give you options. Maybe one day you will write a book that lots of people read. Or you might stand up confidently before a crowd of people giving speeches. You will be great at this, I can see you standing there now talking to the people and then afterwards, you'd look them straight in the eye and shake their hands firmly! Can you see yourself doing these things one day?

**Child:** [laughing] Yes.

**Adult:** Now, tell me back in your own words what you just learned from me right now, because I can see that you are thinking about this.

**Child:** That I should learn how to read because it makes you smart and I should ask staff to read to me.

**Adult:** Excellent! Well done! See, you really are a smart boy! No wonder you were bored just sitting in this room with nothing to do. You need to be active with a mind like what you've got! Would you like to read NOW?

**Child:** Yes!

**Adult:** Let's sit down. [Begins reading a story from Highlights magazine]

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## *Shifting Assumptions*

In working with difficult children, it is easy for childcare workers to become involved in enactments with children that actually replicate the negative experiences the child has already had with adults. In this example, however, we see a connection with a child that broke through the barrier of the presumed assumptions about him. This is the practice of creativity in childcare: playing against the assumption. Once such a reenactment is in play and the adult assumes the child is antisocial, the adult will not talk to the child as if building a rapport will make a difference and as a consequence the interaction between child and adult becomes predictable, rigid, and repetitive. In this example, I had an advantage because I was a fresh face. I only knew what I had *heard* about the child but I remained free to improvise my response to him. When I shifted my stance in relation to the child and decided to assume that it is precisely the child's craving for meaningful social connection and significance that his ostensibly anti-social behavior portends, it allowed the child the freedom of improvising a response very different from his usual response to adults. (Bloom, 1997) I introduced myself to the child as a normal person would. I taught the child a skill – shaking hands – that is expressly required for social functioning and enhancement. I praised him profusely. I challenged him to do it properly. I spoke with enthusiasm and passion so as to reinforce the kind of inspiration required of the creative process. To be creative in any situation related to childcare, we must locate our underlying assumptions and then shift them into a new practice or attempt – we must *improvise*, on the spot. We must be less predictable.

We might ask how it is that we normally talk to children. Or, what are the cemented presumptions that children have of us and that we have of them? What would happen if we dropped them for a new approach? Do we talk down to children and why? What we find in shifting our assumptions for the sake of a creative edge is that we take the children out of their ordinary frame of attentiveness, one that is typically fragmented by their fundamentally bleak view of themselves and the world (Freeman, 1997).

## *Creativity*

Perhaps creativity is the kind of word that is too frequently associated with the – well – creative. We automatically think of certain art forms such as theatre, dance, or painting. The term actually refers to the state of producing, organizing, and inspiring. (Webster, 1996) As with any term, however, it is the context from which meaning occurs.

With regard to mental health, creativity is a concept through which theoretical assumptions are examined, questioned, and then shifted. Bloom (1997) likens the intrapsychic process of healing to the creative process found in artists. In the end, therefore, we see that whatever progress humans make in the area of psychological treatment will spring from the same fount of thought, imagination, and rehearsal from which great art is formed. When we learn to identify and deconstruct our underlying beliefs, the process itself inspires new applications of theories that would otherwise elude us. In short, the

craft of mental health should do very well to “think outside the box” – after first and thoroughly identifying the box. (Freeman, 1997)

In this case of the above dialogue the so-called box is comprised of underlying theoretical assumptions with a potentially correlating creative shift. Whereas the thrust of the theory boxes us in, a creative conjecture opens up options and possibility, even if fluid or without precise form. As importantly, however, we must understand the above adult-child dialogue not just in terms of content but in terms of delivery. The creative spirit in human relations demands the kind of enthusiasm, even theatrics, which is infectious. When a child sees that what we speak of as adults is the same as what we really believe and what we really feel, they cannot help but long for it the same way human souls everywhere and through the ages have longed for the beauty expressed creatively through sculpture, painting, text, and song. In childcare, behold, the childcare worker is the primary creative conduit, through which healing is awakened (Holden, 2001). Notice that part of what made the interaction creative is that I focused the conversation on a particular topic that was unusual or unexpected by the boy: a discussion and lesson on shaking hands; a testimony on the wonders of reading; a framing of his problems in terms of ideas and reading. That an adult staff member could enthusiastically take on a topical discussion that grows from his own imagination and applies specifically to the child’s interest fits structurally to how art functions socially: the artists fashions a sense of life, a temperament, or a message in the form of expression which speaks to the heart by way of particulars. The particulars in this case are almost irrelevant or secondary when considering that the end message is the fundamental message of all of our treatment – the advocacy of hope and possibility. Finding new and engaging ways to do so is the preoccupation of both the artists and the childcare worker. Take a look at the comparison below to consider how the choice of assumption directs the outcome of the adult-child interaction:

<b>ASSUMPTIONS</b>	<b>CREATIVE SHIFT</b>
√ that this boy is difficult	√ that he awakens creativity
√ that this boy is anti-social	√ that he is pro-social
√ that he is aggressive and dangerous	√ that he is uses aggression to try to stay safe with people he considered to be threatening
√ that because he is antisocial there is nothing that can be done	√ that he is full of potential
√ that he can’t learn	√ that he is bored
√ that he does not listen to adults	√ that he’d loved to be spoken to with passion
√ that he is hopeless	√ that he only lacks a compelling proposal
√ he can’t read because he can’t read	√ adults can read to him
√ reading is a drag for a boy like him	√ reading can be framed as the key to the future
√ he does not relate well to others	√ trust and connection must be built

## *How Belief and Language Create Reality*

After hearing the details about this interaction with Nicky, one of the boy's regular milieu therapists said that the encounter changed his assumptions about the boy and opened up an entirely new therapeutic relationship between them, one that 4 months later continues to yield advancements in the boy's treatment and development. This is what the milieu therapist said about working with Nicky during the four months following the initial ad hoc meeting about him:

"I was struck by the question that asked if we knew what Nicky was passionate about. It surprised me that I could not answer it, that I really believed that he was not passionate about anything at all. Even after I explored it I was not able to find anything. But then I noticed that a lot of that is a result of the way he is treated – almost like a little pet that follows adults around but who can't really do anything for himself. I started to wonder if the boy was just bored. I started to look at things from Nicky's point of view...I found that maybe he just wanted attention or wanted to connect with people. I developed a greater understanding of him versus just seeing him as a problem. Even though I had heard that Nicky did not ever want to read, I discovered that he does in fact want to read. He actually asks me to read to him and to teach him to read. I think people misunderstood his frustration over struggling to read as an indication that he did not want to read. This is not true. When I read to him at night, he is attentive and enjoys it. It's difficult for me to describe how Nicky has progressed over the past few months because my opinion is based on the fact that my own view of him has changed. Now that my view has changed of him, I do not see him as the terror that I once assumed he was. He is 9 years old; his personality is not completely developed yet. I see now that I can help to shape that rather than to assume that he is already in a fixed state."

This milieu therapist's unexpected discovery at how his negative beliefs about the child -- in effect -- *created* the logical outcome is a profound, but perhaps too frequently overlooked axiom in human life, an oversight which comes at a heavy cost to the aspirations of the mental health field at large. Solas (1995) speaks about the revolutionary breakthroughs in 20<sup>th</sup> Century linguistic theory by examining the great works of philosophical poststructuralists and then applying the ideas to clinical social work. He writes, "At the heart of dialogical practice lies ordinary language. However, language does not simply provide a means of communication. It actually constructs and re-presents reality...it is the world of words that creates the world of things...language is always a matter of force, to speak is to exercise a will for power..." (151)

## *Conclusion*

Working with seriously emotionally disturbed children in therapeutic communities is an exercise of humanity, where each encounter with crisis provides a chance to either follow old patterns of struggle or to create anew. With the aid of well-established theories, we give ourselves the magnificent light of academic beliefs and

assumptions, as we make our way through the darkness of trauma, grief, and disturbance. But without the ability to question these assumptions while trying out new ones, we grope in vain, resisting the very creative process that got us to any of countless theoretical paradigms in the first place. At last, all old assumptions were once new, sprung from the courageous genius of the human imagination. Even in the field of mental health, we continue to advance our way by two means. We talk. We create.

In the difficult case of Nicky at the Andrus Children's center in Yonkers, New York, the community allowed itself to be tested. By talking through the problems and the layers beneath it, we found our own feelings of helplessness matching the helplessness of the children under our care. We found theories that easily supported our helplessness, perhaps even suggesting that our therapeutic system could not work any longer for Nicky. What if the boy is truly anti-social? How far can a therapeutic residential treatment center extend itself to the disturbing isolation, detachment, and violence of an ostensibly incorrigible boy with the deeply imbedded scars of intense trauma? Perhaps nothing could actually be done, unless of course we continue to talk – creatively. This creative talk opened up varied conversations across campus that paved the way for progress for both children and staff members.

The ultimate symbol of human ideas of course is words. They are both metaphor and literal representations of ideas, possibilities, and imagination. Thus, at every turn we find our actions well rooted in talk. We find ourselves automatically searching for words as a way to pinpoint the next innovation, the next breakthrough of empowerment. (Rassumen, 1995) Talking is so integral to the processes of mental health. It is the great medium of our cognitive approaches. We speak our ideas to make connections, so that our clients can have options for their lives. We operate from the premise that we can design or discover healthy alternatives to old ways of being stuck psychologically.

And so the stories of hope and struggle at the Andrus Children's Center continue to flow just like the river nearby it: in both directions north and south. For the sake of healing the children in our care, we press toward that sense of imminent change foretold by the natural environment of the campus. From the vibrancies of Fall all the way through the fiery light of Summer, we shall in effect recreate William Shakespeare's transformative forest where possibilities abound as, "...tongues in trees, sermons in stone, and good in everything" (Evans, 1974) (Act II .Scene i.Lines 1-17.)

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