RESIDENTIAL GROUP CARE QUARTERLY

VOLUME 4, NUMBER 2 CHILD WELFARE LEAGUE OF AMERICA FALL 2003

The Sanctuary Model: A Trauma-Informed Systems Approach to the Residential Treatment of Children

by Sandra L. Bloom

The Sanctuary Model was originally developed in a short-term, acute inpatient psychiatric setting for adults who were traumatized as children (Bloom, 1994, 1997, 2000, 2003), but has since been adapted by two residential treatment programs for children in New York: The Jewish Board of Family and Children's Services' Residential Programs in Hawthorne, and the Julia Dyckman Andrus Memorial Center in Yonkers (Abramovitz & Bloom, 2003; Bloom et al., 2003).

Both centers recognized a high proportion of their children were trauma survivors and that sending staff to learn various treatment techniques was not enough to create a trauma-informed culture. The leaders of both programs recognized they needed to create an organizational climate that could more effectively provide a cohesive context in which to address trauma in children.

Cedar Knolls, the project at Hawthorne, was in part supported by a National Institutes of Mental Health grant investigating the implementation of the Sanctuary Model in that setting under the auspices of Columbia University, the Center for Trauma Program Innovation, and the Saul Z. Cohen Chair (Rivard et al., 2003). As part of that project, a team of clinicians and research assistants was hired to implement the study. Now that the study is complete, the lead facilitator remains on campus providing training and consultation for the cottages and school that were not a part of the study, so that the Sanctuary Model can be implemented campuswide.

In contrast, the implementation process at the Andrus Center was facilitated by intensive training of a multidisciplinary Sanctuary facilitation team representing every level of the organization, which assumed responsibility for training the entire staff in the Sanctuary Model (Bloom et al., 2003). Although the implementation processes in the two organizations varied, the assumptions, goals, and practices that describe the model are the same.

Embedded in the history of residential treatment settings for children are many debates about how treatment should be delivered and what constitutes treatment (Abramovitz & Bloom, 2003). It was clear from the initiation of both projects that these debates continue to surface in a number of ways:

- lack of a clear, consistent, comprehensive, coherent model for delivering care that could be shared by staff, children, and families;
- lack of communication and feedback among component parts of the system;

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Residential Group Care Quarterly

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Outcome Measures in Residential Group Care: A State Association Model Project, Part II

by Monique Busch

Do residential programs make a positive difference? How do we measure the effect of residential programs on children and families? Part I of this article (see *RGCQ*, Summer 2003, Vol. 4, No. 1) discussed the efforts of Indiana's state association (IARCCA: An Association of Children and Family Services) in the area of outcome measurement. That article provided the background, a brief literature review, measurement instruments, and examples of findings. This article discusses the findings of the *IARCCA Outcome Project Special Report: An Analysis of Outcome Measures for Children in Residential Care, Transitional Living, and Foster Care* (Jackson-Walker, Wall, & Minnich, 2003), funded by Lilly Endowment.

The research is the product of data that were "matched" for children from 1999 to 2002, and included both intake and discharge data. The report discusses the impact of child and family risk factors on outcomes and analyzes the relationships between demographic factors and outcomes (clinical outcomes, functional outcomes, and placement outcomes; see Part I of this article for more information on instruments). The report also looks at the relationships between specific child and family risk factors and outcomes, addressing the following questions:

- What demographic or risk factors were related to outcomes?
- Did relationships between risk factors and outcomes vary with the particular outcome measures?
- Did relationships between risk factors and outcomes vary with program type? (Jackson-Walker, Wall, & Minnich, 2003)

Residential Program Results

The residential care sample for the *IARCCA Outcome Project Special Report* included 3,046 children staying in residential facilities an average of 180 days. The average age was 14.5 years; 56% of the youth were male; and 72% were white, 20.1% were African American, 2.3% were Hispanic, and 5.4% were of other ethnicities (Jackson-Walker, Wall, & Minnich, 2003).

This "matched" sample is very similar to the larger aggregate sample of youth in residential care during the time data have been collected (1999– 2002). Although the length of stay was shorter for the matched sample than for the larger aggregate sample, this is due largely to the matching process (Jackson-Walker, Wall, & Minnich, 2003).

Demographic Factors

Gender was found to be related to employment outcomes and restrictiveness of environment at discharge. Males were more likely to have a negative outcome (Jackson-Walker, Wall, & Minnich, 2003).

Ethnicity was also associated with restrictiveness of environment at discharge. Minority children were more likely to have a negative outcome on this variable than were white children (Jackson-Walker, Wall, & Minnich, 2003).

Risk Factors

Taking psychotropic medication, receiving special education services, and repeating a grade were associated with

more negative educational outcomes. Being a victim of neglect, physical abuse, or sexual abuse; a witness to domestic violence; or a child of an incarcerated parent were all related to more negative outcomes (Jackson-Walker, Wall, & Minnich, 2003).

Certain risk factors appeared to be associated with more positive outcomes. For example, being identified as a delinquent appeared to lead to a more positive educational outcome. Educational outcomes were more likely to be positive if two of the three criteria were met successfully: behavior, attendance, and achievement (Jackson-Walker, Wall, & Minnich, 2003).

Certain risk factors were related to more negative employment outcomes including taking psychotropic medications, receiving special education services, being a victim of neglect, or being a victim of physical abuse. These same risk factors were also related to restrictiveness of environment outcomes, as was being a victim of sexual abuse (Jackson-Walker, Wall, & Minnich, 2003).

Being a witness to domestic violence and being the child of an incarcerated parent were also risk factors related to restrictiveness of environment, or increased likelihood that a youth would run away from a placement. Youth with these risk factors were less likely to be placed in a less or similarly restrictive environment at discharge (Jackson-Walker, Wall, & Minnich, 2003).

Ethnicity

Both white and minority children saw significant negative relationships between psychotropic medication and restrictiveness of environment, psychotropic medication and educational success, special education and educational success, special education and employment success, and grade retention and educational success (Jackson-Walker, Wall, & Minnich, 2003). Some other factors revealed a significant relationship for white children, but no relationship for minority children.

Physical abuse and restrictiveness of environment, educational, and employment outcomes were all significant and negative for white children. Sexual abuse and restrictiveness of environment and educational outcomes were also significant and negative for white children, as were domestic violence and restrictiveness of environment and educational outcomes. The relationship between these variables for minority children, although not statistically significant, tended to go in the opposite direction (Jackson-Walker, Wall, & Minnich, 2003).

There were significant negative relationships for white children between the status as a child in need of services (CHINS) and restrictiveness of environment, and between parent substance abuse and educational outcomes. The factors tended to act in the opposite direction for minority children (Jackson-Walker, Wall, & Minnich, 2003).

Having a parent with a psychiatric diagnosis was positively related to restrictiveness of environment for minority children, but not for white children. The presence of this risk factor for minority children was associated with a greater likelihood of being placed in a less or similarly restrictive environment at discharge, a more positive outcome. This finding is based on a very small number of minority children who had a parent with a psychiatric diagnosis, and should be interpreted with caution (Jackson-Walker, Wall, & Minnich, 2003).

Comparisons Between Residential Program Subtypes

Secure facilities are host to more African Americans and fewer whites than are other program subtypes. Youth in secure facilities had experienced more prior placements and were more likely to be identified as CHINS than delinquent (Jackson-Walker & Wall, 2003).

Residential programs using both public and on-grounds schools included more youth whose parents had a history of substance abuse, and more youth whose parents had a psychiatric diagnosis (Jackson-Walker & Wall, 2003).

In programs using only public schools, youth were less likely to have experienced physical and sexual abuse than those in other residential program subtypes. More youth had repeated a grade, fewer youth had received special education services, and fewer youth were taking psychotropic medications. Single-parent families were more common, and youth were more likely to have a parent who had been incarcerated. Fewer parental rights had been terminated for youth in this residential program subtype (Jackson-Walker & Wall, 2003).

Suggestions for Residential Care Providers

In considering these findings, the research points to several suggestions for agencies working with these clients:

- focus services on primary risk factors associated with negative outcomes;
- understand that youth who are prescribed psychotropic medications are at higher risk for negative outcomes;
- focus services to provide equal opportunities for minority and white youth; and
- understand that youth who are delinquent have more positive educational outcomes in residential care.

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For more information about the IARCCA Outcome Project or the IARCCA Outcome Project Special Report, *contact Monique Busch, Outcome Project Coordinator at 317/849-8497 or mbuschiarcca@aol.com.*

Sanctuary Model

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- conflicts between various levels of staff as to what defines therapy;
- hierarchical management structures that encourage obedience to authority but do not encourage initiative, innovative problem-solving, or direct conflict resolution;
- a relative inability to sufficiently address the enormity of trauma-based problems in children's lives; and
- only partially effective methods for dealing with aggressive acting out.

Clearly, three essential tasks need to be accomplished:

- Develop a model of intervention that could be broadly applied across the population and could be shared between staff, children, and families. This model would be consistent with established good practice and would allow for the uniqueness of each setting.
- Integrate the system with better communication networks, feedback loops, shared decisionmaking, and conflict resolution practices.
- Develop the infrastructure to synthesize a variety of treatment approaches and techniques into a progressive map of recovery for each child.

The Sanctuary Model as applied to adults had evolved over 22 years of use and had previously only been replicated in a state hospital unit for adults in the United States and in a longer-term program for adults in Canada. Although the process of system change had been described, it had not been previously systematized (Bloom, 1997; Bills & Bloom, 1998, 2000; Wright & Woo, 2000).

What has emerged from experience with both residential treatment settings are a plan, process, and method for creating trauma-sensitive, democratic, nonviolent cultures that are far better equipped to engage in the innovative treatment planning and implementation necessary to adequately respond to the extremely complex and deeply embedded injuries these children have sustained.

In the Sanctuary Model, staff members engage in prolonged dialogue that serves to reveal the major strengths, vulnerabilities, and conflicts within the organization. By looking at shared assumptions and goals, and existing practices, staff members from various levels of the organization are required to share in an analysis of their own structure and functioning, often asking themselves and each other provocative questions that have never been raised before.

The continuous focus is on the fundamental question of "Are we safe?" but in the Sanctuary Model safety is understood as occupying four domains, all of which must be in place for an individual or an organization to be truly safe: physical, psychological, social, and moral safety.

Participants must look at the change process itself and anticipate the inevitable resistance to change that is a fact of life in every organization. Staff members look at management styles and the way decisions are made and conflicts resolved. Through these discussions, they learn what it means to engage in more democratic processes on the part of leaders, staff, and children concerning the simultaneous increase in rights and responsibilities.

Staff evaluate existing policies and procedures that apply to staff, children, and families and ask whether they are achieving established goals. They are asked to learn about and become thoroughly familiar with the psychobiology of trauma, the way post-traumatic stress disorder and other trauma-related disorders present in children, and the implications of that knowledge for treatment.

Staff develop an understanding of a conceptual tool for organizing treatment for adults that is known by the acronym SAGE (Safety, Affect management, Grieving, Emancipation) and one for children known as SELF (Safety, managing Emotions, dealing with Loss, and envisioning a better Future; Foderaro, 2001; Foderaro & Ryan, 2000a, 2000b). Staff learn about vicarious traumas, traumatic reenactment, and the importance of understanding themselves and providing support for each other.

As these discussions proceed, participating staff begin to make small but significant changes. By taking risks—trying new methods of engagement and conflict resolution—they feed these innovations and their results back into the process discussions.

They are asked to begin community meetings, or if they are already holding community meetings, to hold them more frequently and take them more seriously as a significant method for changing the culture. In the Sanctuary Model, two community meetings a day provide punctuation and structure for the beginning and the end of the therapeutic day. These meetings are simple, structured, and designed to steadily and repetitively reinforce the social norms of the community.

Staff are encouraged to engage in regular safety planning, collaborating with the children in developing these plans, and simultaneously using the safety planning process as a way of beginning to teach the children the SELF constructs while they are at the same time learning the constructs with the kids.

Embedding these fundamental tasks of recovery as a common language is an essential part of the Sanctuary Model and is supported by the implementation of psychoeducational groups for children that follow a SELF format. As this occurs, the children begin using SELF language, and their developing skill in managing emotional states becomes noticeable. As this process unfolds, the staff members become much more interested in what these children have actually experienced and how that history has determined present behavior.

Through case discussions and an increase in collaborative efforts among various treatment team members, innovative approaches and new discoveries further reinforce the process of continuing change.

It is too soon in the evolving process of culture change in both institutions to determine exactly what treatment approaches and strategies will emerge. It is clear from the people involved, however, that two to three years into the process, change and growth is palpable and satisfying. In a recent review, one program manager remarked, "I feel like I was lost in the woods and the Sanctuary Model helped me find my way out."

A teacher observed,

> A lot of people are communicating better and we are realizing that democracy is messy, it's hard, and people say things we don't want to hear when they are asked to speak. We won't like it all. Some people thought Sanctuary meant everybody being happy—but that's not what it's like. Sanctuary doesn't mean everybody gets what they want—it means everybody is going to be heard.

Another noted with pride "We used to have 30–40 restraints a month and this year I think we have had four for the whole year." The chief operating officer (COO) commented,

> If you walk through the school now and you hear yelling, it grabs your attention. Two or three years ago, you wouldn't even blink because you heard it so much Now you rarely hear adults yell. It has changed dramatically. The whole place is calmer. You just don't hear the high shrill screaming and yelling. That's remarkable because I forget what it used to be like.

Another teacher informed the group

> I had a professor in college who told me that it is good to change your job every five years. Sanctuary has changed me so that I feel like I am at a different job, doing something totally different. The fact is there is no restraint, we are not yelling at the kids, we are using the same language, we derail crises. Restraints with children now rarely happen and [when they do], you look at it as something very unusual and out of the ordinary. It even makes me a better person at home.

At the end of the review meeting with the Sanctuary facilitation team, the COO noted, "Another thing I think is remarkable is that none of you left. This is residential treatment in New York State, and not a single person has left the agency, and you are 20% of the campus programs. I don't know why, but I am happy you are still here." This demonstrates to one and all that dealing with conflict and change—the real business of therapy—actually does help individuals and organizations more effectively manage the stress that life inevitably brings. Work is currently under way to publish a manual to help other treatment programs make similar changes.

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Managing Self-Injury Among Youth in Residential Placement

By Jennifer Bradley

Of all the client behaviors that direct-care staff and administrators must deal with in residential placement, self-injury typically causes the most difficulty. Even well-trained, experienced, professional caregivers tend to respond with fear and sometimes revulsion when clients cut themselves, hit themselves, bang their heads, pull out their hair, or drink caustic fluids.

Clinicians and administrators alike usually hope to squelch the behavior immediately out of concern for their client and potential liability issues. Unfortunately, in the case of self-injury, this impulsive response will typically exacerbate the problem rather than eliminate it.

Why Do Clients Self Injure?

Most clients in residential care who self-injure do so because of their inability to manage symptoms related to past trauma. Children who have suffered through chronic trauma often lose the ability to regulate their emotions. They may feel physically and emotionally numb, or they may be flooded with sensation and emotion. They may have difficulty concentrating and often do not learn from experience. They generally lack the social skills and trusting attitude necessary to establish healthy, supportive relationships. Adolescents who have lived through many difficult life events often have a weak sense of self. These symptoms leave the client feeling isolated, different, and damaged. The person feels out of control and helpless. This sets the stage for the onset of self-injury.

People may self-injure for any number of reasons—specific motives are as unique as the individual. That said, self-injury usually has three main functions:

- It serves to regulate the person's level of dissociation.
- It is a form of communication.
- It regulates interpersonal distance.

Each of these functions is an attempt to establish some control over internal experiences that threaten to overwhelm the individual. Effective intervention for self-injury is predicated on an understanding of each of these functions.

Because adolescents who have experienced chronic trauma typically have difficulty regulating their emotions, their emotional "volume" and level of physiological arousal are never quite at a normal resting baseline. They may vacillate between extreme emotional states with frightening frequency. These teens can either be on "full blast," meaning that they are overwhelmed by painful feelings, or completely "off," so they feel numb.

Emotional numbness is a facet of dissociation known as "depersonalization." Because these states are extremes, they are very unpleasant and often poorly tolerated. Teens will often engage in self-injurious behavior to manipulate the very physiological processes that cause this emotional dysregulation (see Figure 1).

For a person who is in a state of emotional overload, the act of injuring one's self is shocking and sends the person into a deep state of depersonalization, thus creating emotional numbness and a reprieve from emotional overload. In contrast, for a person who is feeling numb, self-injury can be a means to provide the body with sufficient sensory input to turn feelings back on. Thus, self-injury is a means of intentionally altering a dysregulated emotional system. Prior to treatment, many adolescents identify self-injury as their only means of coping with their feelings.

Self injury is used as a form of communication between the adolescent and those with whom the teen shares the experience. Teens will injure themselves as a way of expressing their feelings when they are unable to articulate their experience. They utilize this approach to tell a story. Bearing witness to this story is one of the crucial aspects of therapeutic intervention with those who self-injure.

It's also a way to change the emotional distance in a relationship. Trauma survivors tend to be intensely ambivalent about relationships, feeling vulnerable and lonely with others and when alone. They may self-injure as a way to push others away when they feel ashamed, perceive themselves as unlovable, or feel too vulnerable. Alternately, self-injury can be a means to bring people closer, as caregivers tend to respond to self-injury with increased attention, nurturance, and sensitivity.

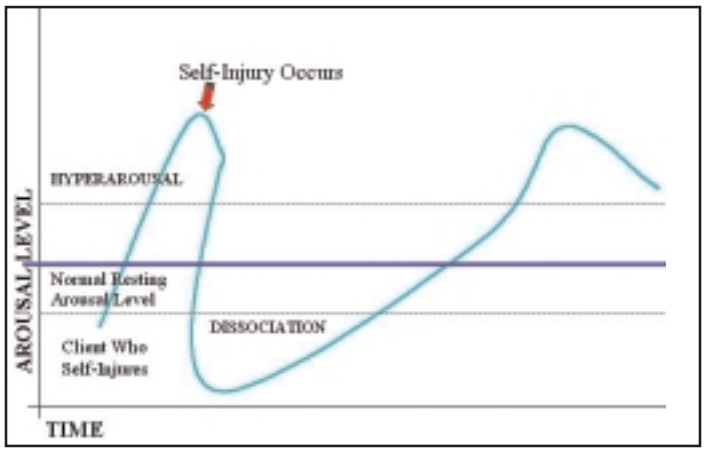

Figure 1. Arousal Level Due to Self-Injury as a Function of Time.

Effective Intervention

The most effective intervention with clients who self-injure does not involve taking extreme steps to stop the client from self-injuring, but rather helping the client gain control of her inner experience in a more adaptive manner, thereby rendering the self-injury unnecessary. This distinction has enormous implications for the caregiver's approach to a client. Encour-aging the client to maintain and work to increase, self-control must be the primary goal. In this way, caregivers work to empower their clients (see Figure 2).

Self-injury occurs in a cycle. It is strongly reinforcing and becomes a habitual response to distress. Caregivers can intervene at four points in this cycle. When these interventions are applied consistently, they will help the client move beyond self-injury.

Developing Self-Awareness

The first step in managing self-injury is helping the client identify his triggers. Triggers, whether internal (such as feeling intense anger or fear) or external (such as experiencing conflict with a teacher), start the self-injury cycle. Daily journaling can help clients notice patterns in their experiences that will provide strong clues about their triggers.

The second step involves helping clients become consciously aware of their level of physiological arousal. They can do this by frequently monitoring their own internal state and noticing connections between emotions and physical sensations. By developing this self-awareness, clients can move to the next step—recognizing when their level of arousal has reached dangerous levels.

Using Self-Soothing Techniques

Clients usually need to experiment with a variety of techniques to identify those that work best for them, but by developing individualized ways to self-soothe, they can derail the cycle of self-injury. Relaxation exercises, controlled breathing techniques, and meditation can all be helpful. Many people find that taking a warm bath, preparing and eating healthy food, wrapping up in a warm blanket, watching a favorite movie, or listening to soft music reduce the level of arousal.

Use of Alternatives

At times, self-soothing techniques may not be adequate to curb the urge to self-injure. If a client continues to express an urge to self-injure, caregivers can help by offering alternative activities. Initially, clients work to distract themselves and begin to delay self-injury. Clients should be commended for their progress in this regard, as a delay of even a few minutes is a sign of increased self-control. Every client should have an easily accessible action plan that may include activities the person can do and people to call for help. Effective alternatives often include exercising, ripping up paper, drawing, journaling, or playing a musical instrument.

If the person continues to feel compelled to self-injure, caregivers can encourage the client to choose the least damaging option. For example, if a client has the urge to cut herself, she may instead opt to immerse her hands in ice water, or snap rubber bands on her wrist. For clients who get relief from seeing blood, alternatives such as using ice cubes with red food coloring, smearing ketchup on the skin, or drawing on the skin with red markers can be very helpful.

Figure 2. Client management of the SIB cycle.

Education and Rehearsal

Clients who self-injure need tremendous education about the processes involved in self-injury. When clients are receiving good treatment they know as much as their caregivers do about the processes underlying their symptoms, the rationale behind the self-soothing techniques, alternatives to self-injury they are trying, and the effects that increased self-control and general empowerment will have on their lives. The very act of educating clients about self-injury is a means of reducing clients' feelings of helplessness, moving them toward taking responsibility for their own behavior.

Moving Toward a Healthy Lifestyle

As clients become more attuned to their emotional and physiological states, learn effective means for soothing themselves, and use alternative behaviors instead of self-injuring, they move progressively closer to a healthy lifestyle. When given the opportunity to develop a sense of control over their minds and bodies, clients can then begin to create a strong sense of self and higher self-esteem. Those results are bound to positively affect professional caregivers and administrators as well.

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Q: *To ensure children's well-being, many states currently require a special, state-level review before allowing children under 10 years of age to be placed in residential treatment. Should obstacles to placing young children in residential care be removed?*

POINT:

Too many young children who have exhausted other, less restrictive placement settings and who could benefit from residential care are caught in a bureaucratic waiting game. The process of placing young children in residential treatment should be simplified.

By Katherine Johnson

As of September 30, 2000, approximately 43,900 children—8% of all children living in out-of-home placements—were residing in residential group care settings (AFCARS, 2002), and only a minority of those children were under age 12. A study of 10,000 children in residential treatment in California, for example, found that 21% of all children in group care were under age 12, as compared with 51% of the entire California foster care population (Fitzharris, 1985). Similarly, a study by Berrick, Courtney, and Barth (1993) found a much higher proportion of older children in residential care.

Assuming the California numbers reflect national trends, only about 9,200 children, or 1.7% of the national population of all children removed from their homes, are school-age children living in residential care settings.

The small number of young children in residential care is evidence of the degree of caution case managers use when referring children under age 12 to residential facilities. Although no one would dispute that less restrictive placement options should be exhausted before referring a young child to residential care, a select group of young children may benefit greatly from

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COUNTERPOINT:

Placing young children in residential treatment facilities has a profound effect on their social, emotional, and cognitive development. To protect their best interests, state authorities should continue to review every case in which residential treatment is recommended for children under 10.

By Casey Holtschneider

Because of its long-term implications, deciding where to place children who have been removed from their homes is always challenging. This is especially true for the youngest clients, who are still in stages of rapid growth and development and require a great deal of individualized attention.

Best-practice methods indicate that children most suitable for residential care are those who need a structured program; whose relationships with birth parents may disrupt foster placement; who are highly aggressive, consistently impulsive, hostile, and defiant; who threaten violence to themselves or engage in acts that pose a danger to the community; whose educational needs exceed community resources; and who have very limited ability to engage or empathize with others (Curtis, Alexander, & Lunghofer, 2001; Dore & Eisher, 1993).

Unfortunately, despite best-practice statements, research to date implies that placement criteria are equivocal and that no definitive guidelines exist for placing any child (Segal & Schwartz, 1985), much less placing young children. Instead, placement decisions are often described as "a highly individualized matter based on a complex set of idiosyncratic factors defying categorization" (Maluccio & Marlow, 1972).

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the services and programming that residential facilities provide. Based on the caseworkers' expertise, as well as family and consumer input, those children deemed appropriate for residential care should be free to access such settings without a time-consuming, bureaucratic review. After all, case managers know their clients' strengths and needs far better than any state official.

Evidence clearly demonstrates that a small percentage of young children who have exhausted other less restrictive placements are in need of the structure that residential care provides. One study found that abused children ages 6–10 in residential care were more aggressive and withdrawn than their nonabused classmates (Howe, Tepper, & Parke, 1998).

Teachers also rated young children in residential treatment as more likely to interrupt others' activities, less social, less well-liked, more likely to have fewer close friends; and less proficient than non-abused classmates in understanding and expressing emotions. Those children were also more likely to have skewed beliefs concerning other people's reactions toward their emotional expressions, revealing some of the socioemotional deficits among young children in residential treatment (Howe, Tepper, & Parke, 1998).

Younger children in group care have also been reported to have significantly more behavior problems than older children in group care (Patterson & Zill, 1989). Such extreme behavior among young children in residential care illustrates the need for such services.

Not only do children in residential settings need intensive services, but a number of model programs have demonstrated success in treating young children. For example, a study of 246 children ages 6–10 living at Childhelp USA, a residential care center, found that young children improved significantly on measures of aggressive behavior, covert conduct problems, attention deficit/hyperactivity, self-destructive behavior, withdrawal/anxiety, toileting problems, and sexual acting out from the time of admission to the point of discharge (Pugh, Tepper, Halpern-Felsher, Howe, Tomlinson-Keasey & Parke, 1997).

Another study found that regardless of age, children diagnosed with conduct disorders who were placed in residential placement made significant improvements on the Child Behavior Checklist Scale from point of admission to point of discharge and maintained the discharge functioning level two years post-discharge (Day, Pal, & Goldberg, 1994).

Research related to long-term group care outcomes suggests that age, gender, intelligence, severity of a youth's presenting problem, type of treatment, and length of treatment are not correlated to children's outcomes (Pecora, Whittaker, Maluccio, & Barth, 2000). Factors correlated to long-term outcomes include family support and involvement, comprehensive discharge planning, presence of supportive community networks, educational support, and a minimally stressful environment (Curtis, Alexander, & Lunhofer, 2001)—all of which younger children are just as likely to have as older children.

Clearly, a select group of challenging, young children need the intensive services that residential care facilities can provide. Case managers who solicit family and consumer input are in the best position to determine whether or not to refer challenging children to residential treatment programs without a lengthy state review process.

Waiting for state approval to place children in an appropriate, long-term setting not only denies children quick access to the treatment they require, but also eats away at the timelines set up by the Adoption and Safe Families Act of 1997. Before achieving permanency, vulnerable children and families must receive the treatment and support necessary to attain reunification. The bureaucratic state review that is often required to place young children in residential care is unnecessary and a disservice to the children most desperately in need of care.

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COUNTERPOINT, from page 8

One study of 250 factors potentially relevant to the placement decision failed to develop any predictive descriptive model of the placement process (Runyan, Gould, Trost, & Loda, 1982). Given such research, as well as the documented shortage of available foster homes, these findings beg the question whether case manager desperation rather than deliberation drives the placement process.

The notion that case managers may be driven by placement availability is reinforced by studies that show that factors influencing the placement process include expediency to the worker (Runyan et al., 1982), parental skills, constraints on funding and program availability, and child-specific demographic characteristics (Kadushin, 1980).

A case file review of 424 residents placed at an emergency shelter found that the most significant predictors of discharge patterns were the place from which a child was removed, the amount of time spent in treatment, age, and race. Evidence reveals that those discharged to a residential care setting tended to be admitted from a nonfamily setting, spent relatively more time in treatment, were older, and were white (Segal & Schwartz, 1985).

Such placement predictors fail to reflect best-practice methods and suggest that case managers may be driven by expediency and availability of the placement setting rather than the child's treatment needs. Further, evidence has shown that once referred to residential facilities, young children are more likely to be accepted than their older counterparts (Pierce, 1985). Taken together, these facts indicate that careful review of the appropriateness of residential placement for young children is not happening at referral or admission. Given the critical developmental stages young children are passing through, state oversight is clearly necessary when placing young children into residential facilities.

In addition to the fact that placement criteria are relatively obtuse, most residential care settings are not prepared to deal with the developmental needs of young clients. According to Maier (1987), school-age children are at an incredibly vulnerable stage in their development as they transition from primary involvement with the microexperiences of home and family to macroexperiences of school and neighborhood exploration. Because young children are in the midst of learning how to best mitigate such transitions, those who experience abrupt personal social dislocation, such as rapid removal from the home and placement in a residential setting, without the support of their primary caregivers, are likely to experience distress and developmental setbacks. As a result, Maier notes that it's important to focus on the developmental needs of school-age children in residential settings: developing personal competence, forming close peer associations, and facilitating encounters with the outside world.

Unfortunately, Maier's (1987) developmental theory has not been widely implemented in the field and, because of this, many young children in residential treatment facilities are not receiving the developmental support they require. Further, there is a dearth of best-practice research regarding the treatment of young children and their families in residential facilities: A review of research priorities for residential care found the field lacked information on the programming necessary to meet the needs of young children (Whittaker & Pfeiffer, 1994). Without a proper research base, providing effective services to young children in residential placement is extremely difficult.

The decision to place a young child in group care is, at best, subjective and, at worst, based almost exclusively on the availability of the next placement bed. Young children

In the next* Residential Group Care Quarterly *Point/Counterpoint:

Question:
Is restraint and seclusion a therapeutic intervention or a therapeutic failure?

Point: Restraint or seclusion is a therapeutic failure. Consumers have described their experience of being restrained or secluded as dehumanizing and humiliating. In addition to consumers' negative experiences, children and adolescents who have been restrained in psychiatric hospitals report painful memories, fearfulness at seeing or hearing others being restrained, and a mistrust of mental health professionals.

Counterpoint: Restraint or seclusion is a therapeutic intervention. Many providers have argued that associating the term* therapeutic failure *with the use of restraint and seclusion is inappropriate, since physical intervention and seclusion is designed to prevent children from harming themselves or others. This term suggests that allowing children to harm themselves or others is therapeutic as long as restraint or seclusion is not implemented.

in residential treatment are at great risk of not having their developmental needs met. Given the paucity of research outlining best practices to serve young children in residential care, it is critical that every referral to such facilities be reviewed at the highest level. It is the only way to ensure adequate protection of our youngest and most vulnerable children.

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Curbing Staff Counteraggression: A Key Component in Reducing Restraint and Seclusion

by Joseph K. Mullen

In recent years, the youth service field has become increasingly focused on reducing the use of restraint and seclusion. In the experience of this writer, the misuse and overuse of these interventions is related to a number of organizational issues, including staff performance. This article focuses on the latter, paying specific attention to the phenomenon of staff counteraggression.

The safe crisis management workshops that my organization offers to educators and youth service workers focus on many salient issues of behavior intervention, none of which is more significant than the concept of staff counteraggression. When asked to describe behavior management in their schools and agencies, workshop participants consistently provide examples in which their colleagues' actions escalated conflict rather than defusing the situation. And everyone has the potential to do the same. It's an instinctual self-protection phenomena that Fritz Redl identified as staff *counteraggression* (Redl, 1966). Our safe crisis management training draws upon the work of Redl, Nicholas Long (1995), and Mary Beth Hewitt (1998, 1999) to provide staff with insight into the phenomenon.

Staff must recognize the "mirror" and "echo" responses they often display when interacting with youth who become upset.

Adults who work with troubled youth do not begin their workday with a plan to escalate the behavior of the youth they supervise. But those who are honest report how frequently they find themselves yelling and even threatening youth to achieve cooperation and behavior compliance. This isn't a planned or trained intervention; it's a counteraggressive instinctual reaction.

Thousands of years of evolution have refined our instincts for counteraggression. What initially guaranteed our Neanderthal ancestors' survival for another day has evolved on both a macro and micro basis. Through the centuries, macro self-preservation activities have ranged from building medieval fortifications to ensure safety from barbarian invaders to the more contemporary nuclear arms race. On the micro level, this evolution has made the most minor social insult a line in the sand that, when crossed, activates individual counteraggressive instincts. It can be the quick retort to a verbal insult, or the road rage we display when another motorist infringes on our driving rights. Counteraggression in humans has a long history and a wide scope.

To avoid heading down this path, staff must first recognize the "mirror" and "echo" responses they often display when interacting with youth who become upset. Evidence of these reactions can be found in paraverbal and nonverbal communication. On these occasions, staff members' tone, volume, and rate of speech begin to mimic the tone, volume, and rate of speech of the escalating youth. Staff members further galvanize youths' negative energy when they mirror the aggressive posture, angry facial expressions, and gestures of the youth in crisis. Staff members are rarely conscious of these reactions.

In addition to recognizing the nonverbal signals they send children and youth, staff members must be aware that behaviors that oppose their own belief and value systems often prompt counteraggressive reactions. Youth in care who engage in such behaviors may prompt feelings of rejection and disrespect among staff, which in turn generate negative energy that can eventually lead to counteraggressive behavior. Although the staff's beliefs may be worthy of reinforcement, the way that reinforcement is communicated can be critical. Awareness and control of one's own hot buttons are vital to ensure a professional response.

The staff's emotional state can also trigger counteraggression. When a staff member is angry, depressed, or just in a bad mood, minor misbehavior is more likely to trigger a counteraggressive reaction. When misbehavior occurs in the middle of the third consecutive overtime shift, staff exhaustion makes conditions ripe for emotional overreaction. Professional child care workers must engage in personal mood management to be successful.

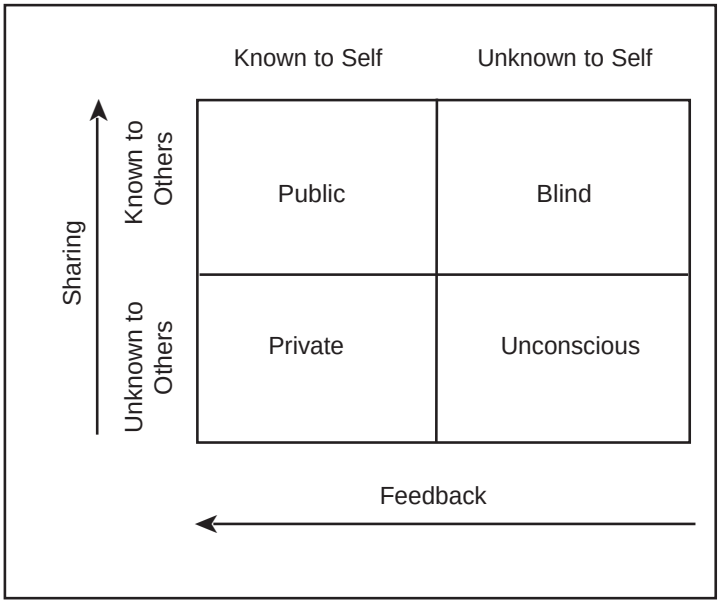

Figure 1.

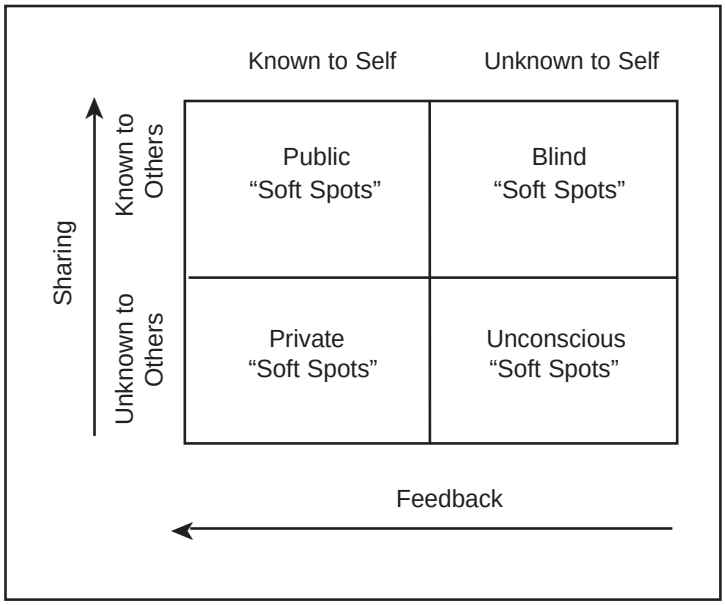

Figure 2.

A fourth common counteraggression stimulator occurs when youth challenge the professional commitment of staff. This is a favorite game for many youth who take pleasure in stating that the staff "don't really care," and "are only in it for the money." Such statements can wound staff, causing an emotional response that in some way strikes back at the insulting youth. One insult can lead to another, and the staff and the youth may find themselves caught up in an incident that escalates out of control.

Finally, there are times when a youth will touch on a caregiver's long-term emotional baggage and trigger a counteraggressive reaction. For example, workshop participants have shared experiences about how accusations of physical abuse by some youth can spark counteraggressive emotions. In some cases, these accusations trigger flashbacks to the personal experience of being physically abused as a child. These staff members may need a time out before being able to continue working.

All of these examples are common interactions for workers and youth in care. Professional responsibility requires that workers become aware of their counteraggressive buttons, triggers, and soft spots and take steps to ensure they are under control. In my experience, awareness regarding counteraggression only occurs through a process of sharing and feedback in which workers reveal soft spots to themselves and others. When this occurs, the soft spots become public and no longer carry the emotional payload that generates counteraggression.

To explain this process, we borrow from the well-known graphic configuration, the Johari Window, which demonstrates the process of personal growth and development (Luft 1963; see Figure 1). The Johari model include four quadrants: the public, the private, the blind, and the unconscious. The model suggests that personal growth and development occurs via the expansion of the public quadrant (known to self and others) by the combination of sharing what is known only to self in the private quadrant and obtaining feedback on the contents of the blind quadrant (unknown to self). This sharing and feedback process takes what has been private or blind and makes it public (see Figure 2). When staff engage in this self-awareness process, the triggers that fire their counteraggression are dismantled. Increased awareness reduces the emotional charge.

To achieve this increased awareness, staff must be willing to engage in a sharing and feedback process with their peers and the youth in their care.

Another way of controlling for counteraggression is to change our perception around button pushing. Based on anger management with youth on probation, the Lane County Oregon Juvenile Probation staff proposed conceptualizing what staff members normally think of as hot buttons as "invitations" (Aarons, Crumbley, & Fraser, 1999). This perceptual shift eliminates the notion of an automatic response button and encourages staff to interpret the youth's behavior as an invitation to provide a noncounteraggressive professional response.

In addition to making a perceptual shift, staff members can also script responses to many invitations to prevent counteraggression. Insults about height, weight, or other physical attributes are easily disarmed by agreement. For example, a staff response to an appearance insult might be, "You know, you're right, I could stand to lose some weight… I should get to the gym more often."

Remarks about one's family or professionalism may be more infuriating and

best handled by emotionally controlled, serious confrontation. For example, staff might respond by saying, "You know when you talk about my family it really bugs me. I wouldn't denigrate your family, so please don't insult mine. Thank you."

These reactions not only help defuse the negative energy in the youth, but also put the youth on notice that staff members are aware of these buttons and refuse to overreact. Preparing responses in advance helps limit the emotional sting of these remarks and allows the staff to model emotional control and assertion rather than aggression.

Dealing with verbally aggressive behavior is a skill most staff members learn with ease. Responding to defiant, oppositional behavior is more difficult. When rules are challenged, disregarded, or broken, the threat to adult authority can prompt feelings of uncertainty, vulnerability, and loss of power. Our usual reaction to such threats is to reaffirm our power, which often translates to threatening to impose consequences. Unfortunately, when staff deal with noncompliance by making statements such as, "Either you behave, or I'll…" in front of a group, the misbehaving youth perceives a challenge from which he cannot back down. In these circumstances, the staff has created a public battle of wills that has more potential for escalation than for compliance.

Instead of responding with counteraggression, adults in charge must view blatant rule violation as an invitation to help the youth choose compliance. Unless the violation is a threat to safety, the staff might choose to temporarily ignore the violation to give the youth the opportunity for self-correction. If a youth corrects herself, staff have a chance to positively reinforce the appropriate behavior. An alternative might be simply asking for compliance followed by "thank you," and then allowing the youth some quiet time.

Another approach is to use the technique of positive correction. This is a step-by-step technique taught in training that begins with a verbal recognition of previous positive behavior and ideally ends with a reinforcement opportunity.

Sometimes a youth will say, "You can't make me do anything!" after which staff can say, "I hope you will make a good decision on the issue." This allows the opportunity for choice, which may be the most salient issue for the youth. After all, clients in youth service programs have very little power—things are done for them, decisions are made about them, and rarely are they asked for input. As a result, youth in care are artificially set up to seek opportunities in which they can exert control. This potential for conflict becomes even more exaggerated for adolescents, who are in a life stage in which a drive for personal independence is only natural. Giving youth a choice can often be empowering. And every good choice made by a youth provides staff with a reinforcement opportunity. In the long run, we will have more success if we catch youth doing something right.

Of course, there are occasions when our empowering efforts are not successful and the need for more direct confrontation is clear. On these occasions, workers who respect personal space, remain calm in demeanor and speech, identify specific behavior concerns, and state clear expectations are the most effective. With this model, youth can still see that they have a choice in the matter.

When responding to the myriad of challenging behaviors and defusing potentially explosive incidents involving youth in care, it's critical to control counteraggression. When staff trainers and program managers emphasize alternative approaches and clearly illustrate the rare occasions when physical intervention is warranted, they will see a significant effect on the frequency of physical restraint and seclusion interventions. When direct care staff learn to control counteraggression and refuse to join with youth in their escalation, they extinguish the fire that may lead to physical intervention, rather than fanning the flames.

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