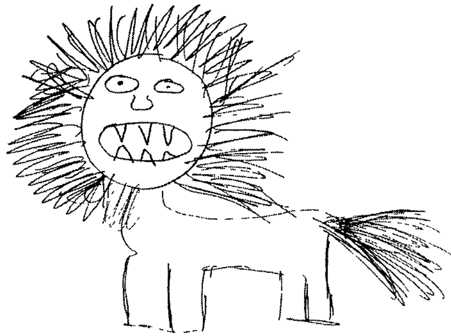

Introduction: What Is Therapeutic Management?

Ralph (age twelve) was admitted to our inpatient unit because he attacked the principal of his school while the principal was lecturing him on his disruptive behavior in science class. He had been disciplined and suspended frequently in the last six months. His biological father wondered whether Ralph could still live with him, his new wife, and his new baby. Ralph is coarse, very fat, wears ill-fitting clothes, and loves to "gross out" girls and adults. When he is angry, he completely loses control and strikes out at whoever is in the way.

Ralph was in the quiet room after he had disrupted our community meeting with lewd remarks about another patient, Maria, and a counselor, Richard. He had also punched and kicked two counselors, Fran and Steve, on the way to the quiet room. He screamed and punched the walls for almost a half hour. I approached him after the door was unlocked. Ralph was lying down on the bench when I came in.

"I heard your roaring and talked to Fran about your clawing," I said matter-of-factly.

"He's a fuckin' liar! I didn't claw him. I don't roar either. What do ya think I am, a fuckin' lion?"

"Yes . . . You remind me of a lion . . . not a very well-behaved lion I've never actually met a real lion, only children who remind me of lions. Well-behaved lions are handsome and strong."

"I'm fat, not handsome. I don't want to talk about this. Talk to those little brats about your lion stuff."

"You said yesterday you weren't going to get angry anymore. You were going to be good. But I told you it wouldn't work."

"I tried. Don't rub it in."

"You need your anger."

Ralph thought for a minute and replied with some bitterness, "Oh sure! Tell that one to my dad's wife."

I was quiet for a moment. "Your anger is like the lion inside. It gives you the kind of guts you need to get what you want and get through the hard times in your life."

"I'm always in trouble."

"I'd rather see you tame your lion and make it your friend. Then you'd know there was something strong and handsome inside to help you when things get tough. You could even introduce him to people, when you learn to like and trust someone." Ralph was listening.

"Would you like us to help you train and make friends with your lion?"

Ralph had been curled up, listening carefully to my words. His arm was covering his face. He began to smile as he spoke. "No. I can bite! I can scratch! What a stupid thing to say," he giggled, then made an imitation roar and a fake scratch in the air. "You're weird."

I laughed at his imitation. "You're not. You do a good imitation of a lion. Can I bring you a glass of water, before you go back to your group?"

"Sure."

Our patients are the discontented, sad, and angry lions in the playing fields and classrooms of childhood. We want them to keep their lion strength, passion, and aggression, within the treatment settings and strategies we create for them. We don't want them to abandon the inner lion but to befriend and tame it.

Taming lions starts with respect for the lion. It requires skill, patience, and love. We offer ourselves to our patients as teachers and temporary lion keepers, until they can become their own. That is the essence of therapeutic management.

Therapeutic management is to the care of disturbed children what normal socialization is to childrearing. The socialization process describes how children's relationships to adults help children develop effective and acceptable ways of

- Getting needs met and wishes granted
- Adaptively coping with stress
- Expressing feelings
- Controlling internal impulses and feelings
- Maintaining a positive self-concept
- Acting responsibly and ethically
- Creating satisfying relationships with adults and peers

The socialization process incorporates the notion that raising healthy children requires adult-child interactions that balance adult modeling of positive behavior, nurturance, discipline, and child participation in problem solving according to the children's developmental stage, temperament, parental values, and personal style.

Although our theory of therapeutic management is modeled on how adults need to interact with normal children to promote healthy development, the process looks different with our patients. Socialization on an inpatient unit incorporates "corrective steps" in the normal socialization process in order to address the consequences of pathological development. Therapeutic management creates a "corrective experience" (Kalogjera, Bedi, Watson, and Meyer, 1989, p. 280). The painful reality of working with disturbed children is that they are often incapable of making use of adult-child relationships due to past distortions in relationships or their own cognitive and ego deficits. Thus, our work starts with the problem behavior and the internal damage caused by pathological development.

The process of therapeutic management is based on what all children need to grow and develop (the components of normal childrearing or socialization) plus the corrective steps needed for emotionally disturbed children who have to get back on the path of positive development. The corrective steps are culled from the history of institutional care of children and child psychotherapies.

A Brief History of Child Treatment

The history of institutional care of children provides the basis of current therapeutic management practices in hospitals or residential treatment centers (Alt, 1960; Mayer, Richman, and Balcerzak, 1978; Noshpitz, 1982; Harper and Geraty, 1987; Whittaker, 1979). Historically, treatment was categorized as having two distinct components: psychotherapy and milieu management. Management tasks were linked to the physical and protective needs of the child, as opposed to the psychological treatment needs of the child. Management in this sense took place in the almshouses of the seventeenth century and in the orphanages, reform schools, and penal institutions that developed in the eighteenth and nineteenth centuries. The patient care in these institutions was guided by the following concerns: religious principles, the need for protection and corrective discipline, an emphasis on constructive work, and a desire for educational reform.

In the late nineteenth century, these institutions began to be transformed into residential treatment settings with a new purpose: to treat the unique psychological and developmental needs of children. Early programs recognized the importance of regimentation, routines, predictable scheduling, and discipline systems. Psychoanalytic theory shaped the design of the residential treatment centers in the early twentieth century. These institutions emphasized that the children's living situation or *milieu* should be protectively benign and separate from the "real" treatment that took place in the psychotherapy office.

Psychoanalytic treatment was based on the centrality of regression and transference as principles of treatment. Thus, programs continued to espouse the separateness of management and psychotherapy. Theorists believed that involving the psychotherapist in the practical realities of the children's lives would dilute the therapeutic relationship. Also, patients would feel freer to regress during psychotherapy without fear that the treatment would influence decisions about privileges on the unit. Adult psychiatric inpatient treatment developed the "administrator-therapist" split to separate administrative (management) tasks

from therapeutic tasks performed by different people (Stanton and Schwartz, 1954). Accordingly, the assumed value of psychotherapy over milieu treatment was incorporated into the education and training of doctors and social workers until recently.

Defining psychotherapy as the definitive treatment and keeping it separate from the work in the children's milieu was questioned and modified when:

- Residential clients and inpatients were more severely disturbed and their problems proved less amenable to change from psychotherapy alone (Noshpitz, 1962, 1971).
- The administrator-therapist split was creating confusion and dubious treatment results (Gutheil, 1982a, 1982b, 1982c; Beck, Macht, Levinson, and Strauss, 1967; Caudill, Redlich, Gilmore, and Brody, 1952; Caudill, 1958).
- Psychotherapists became directors of residential treatment centers (for example, Bettelheim and Sylvester, 1948; Cohen and Grinspoon, 1963; Redl and Wineman, 1951, 1952; Noshpitz, 1962).
- The therapeutic potential in the systematic design of the children's living environment became more obvious.

In the mid-twentieth century, a new model of milieu treatment evolved that specifies an integrated relationship between the milieu experience and psychotherapy. This approach emphasizes the therapeutic manipulation of time and space and of individual and group experiences in order to make the children's living situation itself a comprehensive therapeutic intervention. In this model, the goals and work of milieu treatment overlap in part with the therapeutic goals and work of psychotherapy. Milieu treatment and individual psychotherapy are both "real treatment" working in a complementary relationship with each other.

To summarize, milieu treatment is the therapeutic manipulation of all aspects of the children's living situation. Therapeutic management is one component of milieu treatment.

What Is Therapeutic Management?

Therapeutic management consists of adult-child interactions and interventions that take place in the children's living situation and that are designed to protect, engage, and teach the children. The goal of therapeutic management is to heal suffering, contain and modify maladaptive behavior, promote development of greater competence, and build a stronger and more valued sense of self for emotionally troubled children.

Therapeutic management integrates therapeutic and management values and functions. The word *therapeutic* implies values such as healing, understanding, permissiveness, expression of feelings, insight, individualized treatment, and the primacy of developing therapist-patient relationships. The word *management* means actively doing something for the patient, such as providing shelter and food, monitoring self-care, providing protection, containing dangerous or unacceptable behavior, establishing and maintaining schedules, routines, and rules, and teaching moral development and the development of self-control through the discipline process.

The concept of therapeutic management respects the therapeutic potential in children's behavioral interactions with their environment. The therapeutic interpersonal environment is designed to value the apparently mundane as well as more emotionally significant interactions between children and adults in the course of their daily lives. The process of therapeutic management is made up of even the "little" interpersonal moments when one says "yes," "please," "thank you," or "no," and the moments when one nonverbally communicates pleasure (smile), disapproval (frown), distress (wince), or sadness (tears).

The way a child is handled, protected, controlled, guided, or managed can teach, model, and convey emotional messages that can be therapeutic or nontherapeutic. Consider the situation with a recently admitted patient on our inpatient unit.

> Lisa (age eleven) started making lewd remarks during the Friday night movie. A new counselor, Susan, asked her to stop or leave the group. Lisa blew up, hitting walls, kicking furniture, and swearing at kids and staff. Susan was injured when she tried to get Lisa to the quiet room.

> In our attempt to understand what happened and why, we learned that Susan had felt badly for Lisa and had made an exception to the unit rules for her. Lisa had received her fourth check on a "movie star chart," which meant that she would not be able to go to the Friday night movie. Our routine specified that a child who received nine stars and less than three checks (we do not expect perfection) was invited to movie night.
>
> Contrary to unit routine, Susan gave Lisa another chance, rationalizing that she "didn't know the rules yet." Susan had felt that it was unfair to punish Lisa, who had been through many unsuccessful foster placements and had not seen her mother for over a year. Susan had hoped that her leniency would convey her sympathy and undo some of Lisa's past pain.

This is "untherapeutic management." Lisa learned that she could change the rules and steal the good time. Causing trouble had become her way of easing inner tension, diffusing her sorrow, and ensuring predictable reactions. Susan learned that what you need to give a patient is not always the total acceptance that it feels right to give. Let's rewrite the scenario.

> A half hour before the movies were to start, Lisa earned her fourth check by teasing a younger patient. She knew that if she earned four checks, she would be unable to go to movie night. She was given a choice of spending the time in her room or in the quiet room. Choosing to be in her room, Lisa lay down on her bed and started to sing lewd songs about Susan and a male counselor.
>
> She was asked to stop. When she continued in a louder voice, she was asked to move to the quiet room, where she was told that she could say whatever she wanted with the door shut.
>
> When Lisa refused to move from her bed, Susan was one of the four staff members who tried to walk her to the quiet room. Lisa fought them and needed physical holding and locked-door seclusion. During this struggle, Susan was injured.
>
> Susan observed Lisa every five minutes from the window in the seclusion room door. When Lisa started to cry, Susan unlocked the door and entered the quiet room and comforted her. Lisa uttered a few weak swears through her sobs. Soon she was curled up in Susan's arms and cried softly for about half an hour. Susan said very little. She told Lisa that she was a brave child who had had terrible luck and a lot of unfair things happen to her.

She said that she hoped that Lisa did not blame herself for all of it

The evening ended with Lisa and Susan having hot chocolate in Lisa's room before Lisa fell asleep.

Why is this scenario therapeutic management? The answer to this question is the central theme of this book. *Susan's response to Lisa included ingredients of structure (aimed at containment), followed by nurturance, empathic listening, and talking.* The important point in Susan's encounter with Lisa is the sequence of interventions, which Lisa determined.

How do we give children what they can take in, at a particular moment, to cope with that moment in the best way they can? The star chart was a way to structure and protect those children who would need to ruin the movie time because they did not feel that they deserved the special event or were unable to follow the rules of group living during the event. Allowing children to fail by ruining the movie time is not therapeutic. It becomes yet another failure for children whose lives are already full of failures. The star chart routine gives children an opportunity to weed themselves out of the good time, putting them in control of their lives. The star chart is part of the unit structure that creates a safe adult protective boundary to test and oppose, acting like parental limits in the home. When Susan circumvented this for Lisa, she weakened the unit structure and made the environment less predictable for her, and therefore less safe.

These children and their families take a while to show us what they can take and use. This often means saving our empathy, our praise, our humor, our listening, and our affection while we focus on providing the supportive controls and boundaries that our patients don't have the psychological resources to construct or sustain for themselves.

Our model of therapeutic management is based on the principles of milieu treatment—the therapeutic manipulation of time and space and of individual and group relationships. The model also draws on other concepts borrowed from newer child treatments that focus on family involvement, pediatric psychopharmacology, social-cognitive competence building, and

well-articulated behavior management approaches. Therapeutic management includes:

- *Dynamic* therapies, which offer strategies for developing insight, expressing and regulating intense feelings, changing self-concepts, reworking trauma, and creating healthier relationship capacities.
- *Behavioral and social-cognitive* therapies, which provide techniques and practical programs for building interpersonal, prosocial, and psychological coping skills.
- *Biomedical* treatments, which address anxiety, hyperactivity, attention deficits, depression, and distorted thought processes. In particular, psychopharmacological treatment can increase the child's capacity to make use of milieu treatment by minimizing and buffering the cognitive, affective, and attention deficits that disrupt and distort the child's interactions with people and environmental demands.
- *Systems or family* therapy approaches, which help understand what interactional patterns have been used pathologically in families, sometimes through multiple generations, and why. These same patterns of interaction are reenacted in the relationships children forge with us during treatment.

Therapeutic management is ambitious and imaginative; it effectively reaches children who have profound and pervasive problems. When possible, we will bring the children's families into the hospital living situation so that they can participate in and contribute to milieu treatment. Parents and siblings are the natural models and teachers for our patients.

Some of the most important work in the milieu occurs when we can enhance the parents' capacity to understand, communicate with, and discipline their children. The concept of therapeutic management allows us to talk about the therapeutic potential in the daily interpersonal exchanges between children and their peers, family, and staff. When these exchanges are shaped to be therapeutic, children have the opportunity to develop hope, change behavior, build competence, and gain insight.

Some children, because of their history of conflict and suffering, cannot depend on, relate to, or communicate with other people. Even kindness and generosity stimulate hostility or indifference, as we saw with Lisa. For these "relationship-resistant" children (Trieschman, Whittaker, and Brendtro, 1969, p. 52), we use environmental or less interpersonal aspects of the milieu to soothe and care for their needs, before healing relationships can be developed. These children cannot rely on their fragile capacity to trust or depend on what an adult will do or say.

The practice of therapeutic management harnesses the therapeutic potential of personal relationships for those who can form them as well as the potential of contextual components of the environment. We pay special attention to the therapeutic potential of unit culture, space, and programming of time to create a therapeutic "holding environment" in which children can begin the process of treatment. Work at this level often precedes motivation for or interest in treatment. The systematic design of more protective and growth-promoting environments creates new frameworks for treatment and development.

A Four-Phase Model of Therapeutic Management

We propose a comprehensive model of therapeutic management that organizes diverse management and treatment skills and values into a sequence of four phases. Each phase has a primary goal of treatment. The model is prescriptive in the sense that we act according to what children and their families need, can use, and understand. *Protection and containment of pathology precede interventions to initiate new behaviors and new meanings.*

- *Phase I or Designing the Framework for Treatment* focuses on designing a welcoming environmental and an interpersonal framework of treatment.
- *Phase II or Responding to Trouble* provides "controls from without" for the child who has not developed internal controls.
- *Phase III or Introducing New Ways* helps children learn adaptive skills and understand their lives in new ways.

- *Phase IV or Leaving and Taking It All Home* describes the work of leaving the treatment setting and taking it all home.

All phases simultaneously attempt to protect, engage, and teach children and their families according to their current resources and problems. Table 1 outlines the four-phase model. In this book, we elaborate on Phases I and II and give a brief overview of Phases III and IV.

This model describes the total process of treatment from troubled start to more adaptive finish. Therapeutic management moves from our more unilateral actions during the early phases of treatment to more equal participation by staff, parents, and patients in the process of change and healing in the later phases of treatment.

Table 1. Four-Phase Model of Therapeutic Management.

I. Designing the framework for treatment
   A. The environmental context of the holding environment: culture, space, people, and time
   B. The interpersonal context of the holding environment: empathy, communication, and discipline
II. Responding to trouble
   A. Techniques for the overwhelmed child: controls from without
      1. Quiet room
      2. Physical holding
      3. Seclusion
      4. Mechanical restraints
      5. Psychopharmacotherapy, including chemical restraints
   B. Techniques for the child in transition: picking up the pieces and moving on
      1. Reactive contracts
      2. Child-oriented interventions
      3. Staff-oriented interventions
III. Introducing new ways
   A. New skills: preventive contracts
   B. New meanings: the stories children tell about themselves
IV. Leaving and taking it all home
   A. Saying goodbye
   B. Taking it all home

Thus the shape of the model is developmental. The adult-child relationship becomes the arena for treatment and development. As in development itself, there is no linear path from pathology to health; the course of treatment is uneven and reflects the role of regression in the service of growth and mastery (Siskind, 1982, p. 27).

Sequence of Phases

Our treatment approach starts with patients who lack verbal skills, trusting relationship capacities, and competency-building techniques. Therefore, we need to reorder the normal developmental process of discipline. In normal development, children develop attachments to their parents and learn to comply with parental expectations in order to maintain and strengthen those relationships. Children accept adult supervision and guidance to keep them safe until they can keep themselves safe.

We cannot assume that our patients have developed sufficient controls to keep themselves safe and to be safe with others. Nor can we assume that our patients will not run away from treatment. We cannot even assume patients' interest in changing their behavior in more adaptive directions. I remember an admission interview with Ralph:

> I asked him, "What are the things you don't like about yourself?"
>
> "I fight a lot," mumbled Ralph.
>
> "Do you want to change the fighting?"
>
> Ralph looked up and responded quickly, "Yeah, I want to fight better so that I can win more."

Ralph informed me that the "rules" were different in his town than on the unit. He came in fighting when things didn't go his way. It took some time to interest him in other ways of defending himself and proving that he is a "cool" kid without the use of physical violence.

Our experience with more extreme pathology and acute phases of mental illness requires us to emphasize a different sequence of events than in traditional treatment. *Extreme pathology*

requires immediate and effective attention to safety, protection, containment, and simplification of the environment. It also means that children are unable to use relationships with others or internal resources to cope with stress or solve their problems.

When control of pathology is achieved, we can begin to help the child in other ways. The need to fit the treatment techniques to each child's current mixture of pathology and adaptation is emphasized. A basic position of this approach is that failure to find the right sequence and mixture of interventions indicates an inadequate treatment approach, not an inadequate child or untreatable family.

The sequence of phases also reflects a "one-step-ahead" approach, which leads to the use of active control techniques earlier in a potentially dangerous sequence. In crisis situations, we recommend the early use of interventions such as physical holding, seclusion, and restraints rather than using them as "last-resort" measures. While we recognize that the legislative and legal literature on managing emotionally disturbed children also recommends and in some cases mandates a last-resort (Tardiff, 1989) approach, we believe that stopping children before they hurt themselves or others is possible and desirable.

Phase I: Designing the Framework for Treatment

In Phase I we welcome, set the stage, and then design the framework of treatment, which includes environmental and interpersonal components.

The environmental context consists of:

- *Culture:* the values, philosophy, and atmosphere of treatment
- *Space.* the design and components of physical space
- *People·* the quantity, qualities, and organization of staff
- *Time·* the daily schedule and activity program

The environmental context of treatment is impersonal in the sense that it is designed to meet the needs of groups of children as well as of individual children. It does not depend on an individual child's capacity to relate to adults. All children

entering the hospital receive the same basic environment, which does not depend on whether children are good or bad, motivated or unmotivated. The external structure needs to regulate, protect, contain, encourage, and inspire.

Phase I also involves design of the interpersonal holding environment. Organizational structure and staffing patterns determine how many people will be available for the children, when they will be available, and what their role for the children will be. The interpersonal holding environment defines how they will relate to the children.

The basis for the interpersonal framework is the triad of empathy, communication, and discipline: genuine understanding leads to effective communication and constructive discipline. All children need to be understood, talked to and listened to, and taught values and acceptable behavior. Normal children need these kinds of adult-child interactions to develop, and our patients also need them with corrective modifications.

Our work assumes that without an empathic understanding of the child and family, treatment cannot proceed. Some understanding of the meaning of the child's inner world must precede our behavioral programming. We also need to appreciate the cultural context of the family's style.

In summary, Phase I brings a therapeutically designed "rescue squad" to the patients and their families, who are derailed far away from the tracks of healthy growth and development. The unit's structure and our understanding surround the stranded patients and their families and offer hope that change can take place. This phase constructs the framework in which the work of the next three phases can occur.

Phase II: Responding to Trouble

Phase II is our response to the patients' troublemaking. An effective treatment program for our patients needs to anticipate and respond to the inevitable trouble that the patients will bring. *This phase involves providing that measure of "control from without" that children need to supplement and support the "controls from within"* (Redl and Wineman, 1952). We use a lot of active control techniques

designed to stop or contain problem behaviors while we begin the process of redirecting feelings and conflicts. This phase appreciates the persistence, intensity, and pervasiveness of pathology. With aggressive or persistently suicidal and self-injurious children, this work is for survival of the children and the staff.

The strategies of Phase II can be divided into techniques for the overwhelmed child who is beyond (or below) treatment in the midst of a crisis and techniques for the child who is returning from troubling incidents. Active control techniques are the "external egos" of the overwhelmed child: physical holding, mechanical restraints, separating a child in a quiet room, seclusion (locked door), or psychopharmacotherapy and chemical restraint. After the trouble has occurred, the child needs help "picking up the pieces" and returning to the group and treatment program. The process of the *reactive contract* technique includes routines to help the child complete the process of making a mistake, taking a penalty, making amends, receiving forgiveness, and experiencing self-forgiveness. This process allows the child to return to the community and relationships in the community following a crisis.

The interventions in this phase sound extreme, but they keep the treatment environment safe and demonstrate to the children and their families that control is necessary and possible. Therapeutic work depends on the perceived safety of patients, staff, and family members. When we respond with limits to the children's need to cause trouble, we spare the patients the burden of more guilt and shame about their actions and the increasing anxiety that results from a sense of power in the face of no control.

Therapeutic management in Phase II must clearly distinguish between the legitimacy of all emotions and the necessary limits on "some" behavior. *We are "permissive" about wishes and feelings but we "set limits" on behaviors that violate the rights of others or jeopardize the patients' safety.* We continually make the point to our patients that we have never known a bad kid, but we have known a lot of kids who did bad things. *The problem for our patients is not the size of their anger (or any feeling), but the size of their controls.*

In summary, our work in this phase is focused on stopping the negative cycle of stress and conflict, followed by maladaptive coping, which produces more stress and conflict. Containing troublemaking can begin again the process of building internal control through the children's experience of external control from without and identification with adults who have and use their controls.

Phase III: Introducing New Ways

In previous phases, the child has learned what not to do. In Phase III, the child learns what to do instead. Once the "trouble" is contained, therapeutic management can move on to strengthen and teach positive responses that are in fact incompatible with the previous disrupting behaviors. Therapeutic change requires reciprocal development on both of these fronts: "To do one without the other, to provide new experiences without the opportunity to organize them internally, or to provide internal restructuring without the opportunity to learn more competent behaviors, is to fail to provide the balance of skill and understanding necessary to cope with challenging future experiences" (Hornik, 1987, p. 8).

Interventions in this phase include "life-space interviews" (Redl, 1966a), time-out procedures, staff praise and positive programs (star charts), and proactive contracts that anticipate trouble and program alternative behaviors. The child may have used these interventions in previous phases of treatment, but during phase III they become the focus of our work. By this time, the child has a "working ego," entailing some control of impulses, some capacity to regulate intense feelings, and some capacity to perceive accurately and make use of what we are saying and doing and why we are doing it. The child also has some motivation to learn and practice new skills, because there is now some hope that the old pattern of failure can be changed.

This is where our treatment begins to look more like what psychotherapy with children is "supposed" to look like. We look toward the behavioral and social-cognitive therapies for the guid-

ing principles and practical strategies for skill building (Barth, 1986; Herbert, 1987; Hersen and Van Hasselt, 1987; Kendall and Braswell, 1985; Spivack, Platt, and Shure, 1976; Strayhorn, 1988; Werry and Wollersheim, 1989). We focus on programs that develop skills our patients need, such as anger control, problem solving, and social skills training. It's in this phase that dynamic therapies can provide guiding principles and treatment strategies for developing insight, expressing and regulating intense feelings, changing self-concepts, reworking trauma, and creating healthier relationship capacities.

Fostering insight is now a complementary process. It works hand in hand with limit setting and skill building. We listen to children's stories and help them understand the assumptions they have used to organize their life experiences and their enduring internal self-images. We encourage questioning old assumptions, using new ways of "researching" old concerns and considering new ways to understand old events.

Considering new answers often involves changing old story lines. For example, Lisa figured that she was a "rotten kid" and that is why she had had so many foster placements. We helped her to reexamine that notion. She began to believe that maybe her failures in all these homes were not all her fault. Maybe she was not a rotten kid. Maybe she did not know how to behave, because she had never had the experiences that children need to teach them how to live in families. Children cannot believe in their own worth unless we help them to understand that they neither caused nor deserved some of the badness that has happened to them. Their assumptions about themselves—how good or bad, how competent or incompetent, how effective or helpless—are the building blocks of their developing self-concept. It is this sense of self that filters what is happening and what will happen to them.

In summary, the work of Phase III helps children develop new skills and new meanings. This in turn leads to greater competence and the integration of these changes into a healthier sense of self. The purpose of this phase of work is to help children fashion a more accurate and benign self to carry wherever they go.

Phase IV: Leaving and Taking It All Home

How do we make the gains of hospitalization portable? Building a good bridge to home does not begin near the time of leaving. The framework of treatment has continuously brought the patient's outside world—family and agencies—into hospital treatment.

But therapeutic management at this phase involves even more contact with the world outside of the hospital. Children visit old and new schools to adjust to new schedules, new expectations, new rules. Visits home continue and visits to new homes start if placement outside of the family is needed.

Families make visits, too. If their children are not going home, we help parents learn about how to remain active participants in their children's treatment in new settings. They learn to transfer their newfound confidence in getting help to new people and new settings. We hope to help the children and their families "consolidate" their gains and "generalize" new, more adaptive ways of coping to home or outside hospital settings.

This involves a careful structuring of the "goodbye" experience to reduce regression and to provide models for handling the emotion-laden experience of leaving and losing. We acknowledge with the children and the families the mixed experience of positive and negative feelings that accompany change, fostered by the losing and gaining involved in all changes. For patients who have had frequent and often traumatic losses, this phase of treatment is as precarious as our initial work during the starting-out phase.

This is a sketch of the entire journey through treatment.

A brief description of the population is necessary before we proceed on our journey.

Who Are the Children and Their Families?

Our patients are similar to the seriously impaired group of children described in other samples of psychiatrically hospitalized children (Berlin, 1978; Hoffman, 1982; Kashani and Cantwell, 1983; Weinstein and others, 1989).

Our patients are commonly called "troublemakers," "psy-

chiatric cases," and children with "adaptive or ego deficits." Each of these descriptions suggests a differing but overlapping perspective growing out of a particular treatment setting and treatment approach: juvenile detention and residential settings, psychiatric hospitals, foster homes and special schools.

Troublemakers

Our patients make trouble for others and for themselves. They have troubled feelings and thoughts that lead to very troubled behavior. Hospital intake forms often describe the trouble they make: physical and sexual assaultive behavior; vandalism; stealing; suicidal behavior; fire setting; alcohol and drug abuse; distorted and bizarre thought and behavior; severe depression and anxiety; and detailed accounts of how hard these children are to manage in families, schools, and communities due to extremes of noncompliant and oppositional behavior. Pervasive behavioral and psychological problems have caused them to fail in family, school, and community settings.

We need to anticipate and be prepared for such trouble in our treatment framework. We view these "bad behaviors" or "symptoms" as the best efforts of incompetent children to cope with the challenges of their lives.

Psychiatric Cases

Our patients can also be described by psychiatric diagnostic labels. The most common psychiatric diagnoses of our patients are:

- Disruptive behavior disorders, including conduct disorders, attention-deficit disorders, oppositional disorders
- Post-traumatic stress disorders
- Mood disorders, including bipolar and depressive disorders
- Psychotic disorders, including pervasive developmental disorders, schizophrenia
- Developmental disorders and personality disorders

Most of our patients carry more than one primary mental illness diagnosis and have moderate to severe developmental problems, neuropsychological diagnoses, histories of severe stress and trauma, and long-term problems in adjusting.

These labels are useful as guides in the choice of the biomedical components of therapeutic management, especially psychopharmacotherapy. Psychopharmacotherapy is an integral part of inpatient treatment of children with attentional problems, psychosis, aggressivity, agitation, anxiety, and affective disorders, primarily depression (Dalton and Forman, 1992; Popper, 1987). The more severe, complex, and acute the psychiatric diagnostic picture, the more likely patients will need and benefit from advances in pediatric psychopharmacology. On an acute inpatient unit, virtually all patients will be candidates for trials of psychotropic medications.

Psychiatric diagnoses can also be used to describe limiting factors in the design of therapeutic management programs. For example, when children have major language disorders, we will modify the use of language. When children have attention deficits, we will try to adjust rules and routines to provide the degree of structure these children find helpful. When we have hyperactive children, we can use active time-outs (for example, time on exercise bicycles), if sitting on a chair proves to be too demanding. Or if children continue to have psychotic symptoms, in spite of active psychopharmacological treatment, we modify our language and our structure to anticipate the more vulnerable world in which they live.

These children's pervasive behavioral problems are the product of a massive developmental failure and failures in socialization. Biomedically, these children often have neurological deficits in perception; impaired synthetic or integrative functions; severe attention problems, sometimes accompanied by hyperactivity; moderate to severe language disorders involving receptive, expressive, and processing deficits; learning disabilities; major mental illnesses like affective disorders and psychoses; and genetic vulnerabilities due to family histories of psychiatric illnesses, such as schizophrenia, affective disorders, alcoholism, or psychopathy. Psychologically, they have poor self-esteem,

defective object relations, poor impulse control, maladaptive coping strategies, and immature defenses. Socially, they frequently have lived in poverty or with overstressed families in which loss, violence, neglect, and abuse have created chronically chaotic family environments.

Interactions of biological, psychological, and social factors have created childhoods that foster failure, incompetence, emotional emptiness, negative self-image, and low self-esteem. Many of the parents of these patients were also burdened by their own share of inadequate parenting, neglect, trauma, and poverty. They are caught in negative cycles of parent-child interactions, with emotional burdens of hatred and despair and ineffectual efforts to get out of all the trouble. Frequently, the children they need to parent are unusually difficult to parent from the beginning, due to difficult temperaments and biological vulnerabilities, such as neurological and cognitive limitations.

Children with Adaptive or Ego Deficits

These patients are children who cope poorly and have failed often at what they are trying to do. They don't like themselves. Their adaptive deficits invade every arena of their lives. They suffer frequent failures and setbacks in their efforts to negotiate the social, cognitive, physical, and psychological tasks of childhood. They don't trust or depend on adults to be helpful, and they often blame adults for their troubles. They hold pessimistic views of their current and future lives. They have ingrained negative self-images, inadequate capacities to relate to adults and peers, and vulnerable self-esteem.

Our patients have poor track records in less comprehensive and intensive treatment settings. Their problems are too severe and too pervasive. They have been described as "beyond the reach of education and below the grip of the psychiatric interview technique" and "as children who hate" or the "ego deficit or predelinquent child" (Redl, 1966b; Redl and Wineman, 1951, 1952). They have also been characterized as "relationship-resistant" (Trieschman, Whittaker, and Brendtro, 1969) and, more recently, as "abuse-reactive" (Small, Kennedy, and Bender, 1991).

Redl and Wineman's (1951) dam-and-lock metaphor captures the inner happenings of ego-deficit children. They compare the ego to a system of dam and locks on a water reservoir. When a flood occurs, the problem could be with the quality of construction of the dam and locks or the quantity and intensity of the water flowing through the system. Even a well-built dam cannot withstand the water flow of a hurricane, and a poorly built dam will collapse when a normal amount of water flows through at a normal speed.

The dam-and-lock system is like the child's system of ego capacities. This system includes the child's capacity to regulate emotions, maintain relationships with adults and peers, cope with stress, develop social skills, solve problems, master past trauma or hurt, and maintain an accurate and positive image of the self. Inner emotional turmoil and external stress and trauma can overwhelm this ego structure even if it is well made and well maintained. When the structure is weak and incomplete, it can easily crack under normal circumstances. Our patients have weakly constructed ego structures, and many of them have overwhelming histories of stress and trauma.

Conclusion

The four phases of therapeutic management described in this chapter have been designed to create an external and interpersonal treatment setting to heal the damage caused by the biological and social histories of our patients. Treatment interventions are borrowed from the history of institutional and psychological treatment of children and from the ingredients of the normal socialization process. The sequence of interventions follows the psychological capacities and needs of the patients and their families. We first act as the "external egos" that facilitate positive development and therapeutic repair. Then we help our patients rebuild the internal egos needed to live their lives with more competence, self-confidence, meaning, and fun.

Let the lion taming begin!