What is harmed by relationship can be healed by relationship: A developmental/relational approach to residential treatment for young children.

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Introduction

Children whose earliest relationships have been marred by violence, chaos, abuse, neglect and loss find that these experiences are 'hard-wired' into their brain. As a result, they will grow up believing that these negative experiences reflect what future relationships will be like. Their way of seeing and interacting with the world has been permanently altered by their earliest adverse experiences. Treatment – with a known healing agent, administered in adequate dose and for adequate time and with adequate intensity – can bring those children back into relational health. The curative factor is a relationship with direct care staff. In this paper, the author will describe a developmental/relational approach to residential care for children which has been used at *Intermountain*, a treatment facility in Helena, Montana, USA, for 27 years. A description of the approach, a case example and the necessity of supervising and monitoring staff are provided. Outcomes of this approach are also detailed.

The need for relational interventions

In 2008, almost 15,000 children in Scotland were looked after by social services and more than half of these children could not remain in the care of their birth parents. Eleven percent of the looked-after children were in residential centres across Scotland (Scottish Government, 2008). They came to these places for a variety of reasons, but the common denominator of their referrals was that the adults in their lives could not care for them safely in a family setting. This means that something about the parents' relationship with the children was amiss, and that led to the removal of the children and the placement of those children into alternate care.

The children who have come from backgrounds of neglect, chaos, drug abuse, and physical and sexual abuse at the hands of adults typically have oppositional or violent behaviors that make them a danger to self or others. On a recent trip to Scotland, I had the opportunity to visit some residential centres. In one of them, I met a boy whose hand was bandaged from his breaking of a window in anger at his mother who failed to come for an appointed visit. This

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is dangerous behavior and the boy clearly had difficulty modulating anger and frustration. The boy was not 'bad', nor was this his problem alone; it was a relationship problem between him and his mother which grew to encompass the boy and the residential staff (and the window). The likelihood is that he had been raised in an environment in which impulsivity and violent expression of anger were embedded in important relationships. He certainly did not have a 'mental disease', the label which American care would have given him. Rather, he had integrated and incorporated a way of being from his home environment that was not safe for him or for others.

It takes patterned, repetitive interpersonal experiences to shape the brain of an infant (Chugani, 1998; Perry & Szalavitz, 2007). It is that 'hard-wiring' of the child's earliest experiences that determines how the child responds to stress, where the child sees danger and how the child responds to frustration, safety and threat. It is interpersonal experience, then, through the closest of relationships, that leads the child to experience the world as safe or as dangerous. We know that the brain continues to be malleable throughout life, but it still takes patterned, repetitive experiences to change patterns established in infancy. If those patterns were established in harmful or neglectful relationships, then it is healthy, containing, present and nurturing relationships that can heal the child.

Children in care have behavioural and emotional dysregulation that makes it difficult for them to live in a family setting, and the early adversity that causes them to be looked after also contributes to ill health and early death in adulthood (Anda et al., 2006). They are not just suffering from a lack of positive experience; indeed, even if you place these children in the most loving of homes, they often seem to negate the positive and appear intent on ruining the relationship that is intended to help them. This raises a challenge for those who look after the children, to find ways to mitigate the behavioural, emotional and physical after-effects of inadequate parental care and childhood adversity and to move these children back into relational health. Staff can consciously and intentionally create therapeutic relationships that bring the child back into a regulated, integrated state in a congregate care setting, such as a residential home. They must, however, do it consciously and intentionally and measure the effectiveness of those interventions in terms of the child's reduced acting-out behaviours and the parents' increased capacity to parent the children in a safe and caring way. This is a treatment approach – to mark the behaviour to be modified, to implement the healing agent intentionally, to measure the change in the behaviour and then to ensure the generalisability of the behavioural change outside of a contained setting.

One treatment approach that uses relationship intentionally as the healing has been used at *Intermountain* for the past 27 years and is a developmental / relational approach. Young children with severe emotional disturbance, aged

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between 4 – 12 at admission, stay in one of four cottages for 18 months to 2 years so that they and their parents can experience new and healthier ways of relating and of getting their needs met.

A model of Developmental/Relational Treatment

The developmental piece of the approach is to determine the developmental origins of the child's disturbance. Questions which are asked include the following:

- When did it first occur?
- What were the family-of-origin issues that were at play in the home during infancy?
- What is the child's template for relationship, for safety, for expression of anger?
- What was the child's attachment pattern?
- What were the child's experiences of parental emotional regulation?
- What were the early experiences of loss, of neglect, or abuse?
- What is the source of the child's oppositionality?

What one can see in most of the children at *Intermountain* is that their behaviour is an expression of an agitated temperament combined with chaos, loss, violence or neglect in the early maternal relationship. If we know how and when the problems develop, it gives us a clue as to how far back we need to go with the child. For example, if the problem developed in very early years, does the child need the patterned, repetitive experience of rocking or of singing or of playing? If we assume that the child's behaviour is telling us something, and that the something is an unmet need or a trauma reaction or a deep-seated fear of others, we have a better idea of how to meet the need and move the child back onto a healthy developmental trajectory.

It is known that the brain has the capacity to change throughout life, although the plasticity reduces dramatically after the first three years (Perry & Pollard, 1998). The implication is that with each year past the age of three, changing the way the child sees the world will be more difficult. The healing agents may need to be in greater number and in greater intensity. It may take a village of like-minded professionals, such as you would find in a residential treatment centre, rather than a family or unintegrated community care, to surround the child with sufficient regulation and modulation and with sufficient positive regard, to change the way the child actually sees the world. This is the relational part of a developmental/relational approach, and with care and intentionality, it can be implemented successfully in residential treatment.

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A Case Example

I will now look at how this works in a specific case. Michael is a very bright, very verbal 12 year old boy who was referred for violent aggression towards others, including punching a teacher in the face, and severe suicidal ideation and attempts, and unremitting oppositionality and defiance. Prior to coming to Intermountain, he had been placed in a psychiatric hospital on five different occasions, and was moved more than 16 times. Michael's birth mother drank and probably used methamphetamine while he was in utero. She never parented him; rather she gave him to a series of family members to raise. Each of the succession of families had little time and energy for Michael, who became increasingly fussy, inconsolable and aggressive with other children. One aunt beat him severely with a coat hanger. Michael was shuttled between Mississippi and Oregon, two US states which are about as far apart culturally as they are geographically.

Michael has a tuned-up nervous system that registers threat easily, most likely from in utero exposure to toxins. He has never had a secure attachment due to his numerous placements throughout his life. He has no capacity to regulate his internal anxiety through relationship. As a result, even minor stressors (for example a fire alarm going off), or small frustrations (for example, not getting the snack he wants), trigger full blown violent rages. Michael has the patterned, repetitive experience that he will never be able to stay in one place; that as soon as he relaxes, the adult will hurt him or kick him out. A coping mechanism that Michael has learned is to argue with adults. This keeps him in control of the interaction, at a safe distance, and sometimes he can even win the argument and get what he wants. The downside of this coping mechanism is that adults respond to a child who exerts control by becoming more dominating, more controlling and more bullying. This triggers Michael's fear response and soon he is attacking the adult as if his life depended on it.

The developmental assessment, then, suggests that Michael needs a close, connected and intimate relationship that provides structure and connection but also physical nurturance and emotional intimacy. He needs to be rocked and sung to and have stories read to him; to be walked with and played with and have his back rubbed. He may be 12 years old, but he has the emotional needs of a hungry toddler, so food is also very important to him. The length of stay is also a developmental need. He needs to be in one place long enough to know that someone can keep him safe and cherish him. In addition to this, however, he also needs to be have real relational consequences for his aggression; consequences in which the relationship is sustained and repaired. The outbursts must be safely contained, but he must also be given the tools to decrease his arousal level before it gets out of control. The relational consequences of disappointment and anger when he has erupted must be titrated depending upon the security of the relationship. If the relationship is

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important to Michael, the disappointment will be effective; if it is not important to him, the staff's disappointment will only solidify his sense of shame and his expectation that he must discard the other before he is discarded.

The direct care staff member creating the intentional intimacy with Michael needs to be joyful, playful and delighted with him. She needs to use the PACE stance (playful, accepting, curious, empathic) articulated and trained by Dan Hughes (2004). She also needs to be emotionally strong enough to resist Michael's attempts to engage her in a fight. She may need help to move out of this situation when she is engaged in the verbal control struggle. She needs to see Michael as a small, frightened child, while holding him accountable for his aggression towards others. It is this one relationship, then, that has the potential to heal Michael. The other professionals involved with Michael – the teacher, the doctor, the therapist, the soccer coach, the other staff – have their role to play. They get to cheer him on, and give him consequences and increase his frustration tolerance, and help him examine how he came to be the way he is, help him learn the hard things in school, have friends and develop skills; however it is the direct care staff who rock him to sleep every night who will change Michael's experience of himself.

In developmental/relational treatment, the adults take the responsibility to keep Michael safe. The adults must ensure that he is safe, being fed, feeling supported; the adults must demonstrate through their actions that they are trustworthy and capable of knowing and meeting his needs and ready and able to take responsibility if he is not safe. If Michael gets upset, he is brought close, not sent away. There are only two rules in this approach – we must know where the child is at all times and the child may not harm another by words or actions. It is the adults' job to monitor the child's arousal level and to work actively, through confronting, distracting, rocking, walking, soothing, talking or more complex group regulation, to modulate the arousal. It is essentially the work of becoming the child's in situ parent, to read the need underlying the behavior and meet that need, just as the new parent must learn to read and meet the newborn's need. All other daily decisions – whether the child can go outside to play, play a game, visit a friend, watch a movie or go to his room – are based on the adult's assessment of whether the child is trusting in the adult care. As the child internalises the care by seeking staff comfort and structure, the structure diminishes and the expectations increase.

In the first two months of care, Michael had 51 dangerous aggressive outbursts. By the time he was six months in care, he had 25 over a three-month period. He increased his time in school and his capacity to deal with frustration. He has become a peer leader whom other children want to be with. He has an aunt who is devoted to caring for him once his placement is completed, and who is learning how to parent Michael differently than she parented her own

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children. Michael's arguing behaviour is diminishing. He is able to rock and cry and talk of his fear and loneliness, instead of acting it out in aggression or suicidal threats.

The Staff

An especially important part of a developmental/relational approach is the selection and recruitment of the direct care staff. It is the direct care staff who provide the '24-7' therapeutic milieu. It is the way that they relate to the child that has the potential to change the child's world view. It is not what they say, or whether they are smart, it is who they are. It is their ability to be someone for the child, not do something to him that is the agent of change. It is the direct care staff who provide the patterned, repetitive structure, care, fun, and connection as well as confrontation, saying no, and being with the child in pain that allow the child to open himself to a world of trust.

The staff's capacity to engage in deeply connected, intentionally intimate relationships with disturbed children, to engage in the dance of attunement, is to a great degree dependent upon their own ability to be curious about their own dances of attachment, their own history. Dr. Dan Siegel noted that the strongest predictor of a child's secure attachment is the adult's ability to have insight into his own inner workings, to be curious about himself (Siegel & Hartzell, 2003). Staff who work with these children, then, are selected on the basis of their ability to be curious about themselves and to see themselves as the instrument of healing. In the initial interview, we let them know that the children will pick up on any unresolved issue from their past, and wonder with them what would get in their way of connecting with a child.

Sustaining an interpersonal milieu is a constant task and a relational treatment centre is a fragile ecosystem that must be attended to with vigilance. At Intermountain, each week, each treatment team engages in a 'Family/Team Dynamics Process' – a group process in which staff explore what has triggered them emotionally in the past week, whether that is a child, another staff, a parent, or something in their own lives. Their teammates help them explore that and examine the ramifications of the experience on the effective care of the children. A staff member's capacity to be curious about his own inner workings and to grow in ability to be more responsive and less reactive to the children directly affects the staff's ability to be given more responsibilities, more advancement and increased salary within the agency. Thus, the feedback from the team is a critical element in each staff member's yearly performance appraisal and in the annual development plan.

Here is an example of how this works. In one team recently, a female staff member told her team of her history of sexual abuse. She explored the extent

to which some of the more sexualised and violent children triggered the fear and immobilised her. The more frightened she becomes, the more she withdraws from the sexualised or aggressive child and the more those children come after her. She is less able to be with the children in their painful experience. That, however, is her job. A week later, her work partner, a male, noted that in his family of origin, he was the peacemaker who stepped in between arguing parents. The team reflected that he was doing the same thing on the floor, and as a result, the children saw the female as weak (and hence did not follow her instructions) and the male as strong. The children being more oppositional towards the female exacerbated her fear of being helpless and his experience of being burdened by another's weakness. It also provoked a higher level of anxiety among all of the children, since several of them came from situations in which the dominant father figure was violent towards the weaker female. In short, as a result of the Family Team Dynamics Process, the male staff member stepped back and the female staff member stepped forward; the children's anxiety reduced and the staff dyad became more effective in working as co-equals. The female staff member's regulation of herself is included on her development plan and in her potential to become a senior staff. The male staff member's ability to allow others to struggle is on his development plan and affects his potential to become a senior staff who can train others.

These staff and the entire agency must be guided by a unifying treatment philosophy. It is the unifying treatment philosophy that supersedes political battles, or funding streams or arguments about interventions. The treatment philosophy is that nurturance is a child's right and is good for them. It is not about whether a child has been good, but rather what is good for the child. This philosophy trumps even a child's right. None of us as parents would agree that it is a child's right to stay home from school or to eat as much sugar as he wants. Sometimes adults have to make the decision about what is good for children. That is our job as adults, and certainly our job as treatment facilitators. As far as the child's parents are concerned, it is also our job to help them to parent the child in a way that reduces the child's anxiety and meets the child's relational needs. When we as treatment facilitators are clear about this, parents can be clear about this as well.

The developmental/relational model of residential treatment, uses a unifying philosophy to choose and train staff and understand the meaning of a child's disturbed behavior, and uses patterned, repetitive relational responses to change the child's experience of and interaction with the world around him. It is a treatment approach that demands professionalism and personal growth of all who work with children. As one staff noted: "It is not a job; it is a way of life."

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Outcomes

In addition to measuring each child's individual progress across time through treatment plans, *Intermountain* also measures all children's progress on standardised behavioural measurement tools across the two-year span of care. Table one depicts children's progress across the two-year span, measured using the Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, 2000). A higher score on this scale denotes more severe disturbance and would indicate that a higher level of care is needed. A score of 140 indicates the need for intensive services and a score of 50 – 90 indicates the need for outpatient care alone. The changes in scores from one year onward represent a statistically significant change from admission. These data are from 2001 – 2008.

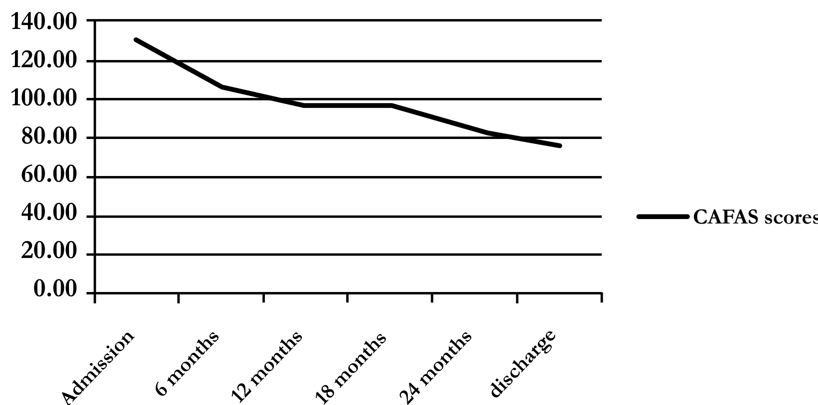

Table one: Average scores on the CAFAS for children at Intermountain from 2001 – 2008.

A second measurement of outcomes is the children's capacity to live in a family at discharge, and at one and two years post discharge. Table two is the cumulative data for care across a ten-year span from 1991 – 2001.

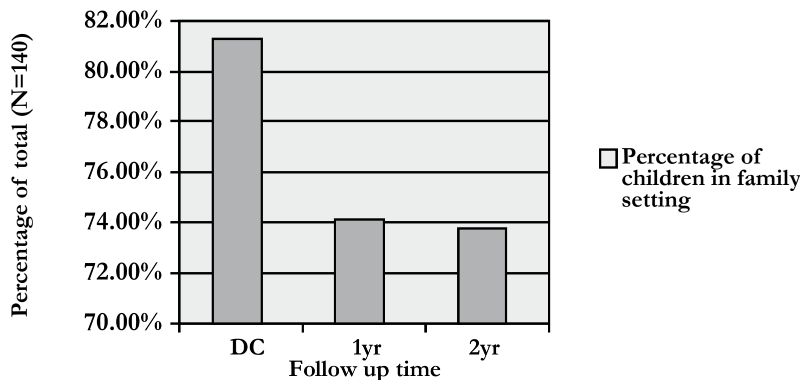

Table two: The percentage of children discharged to a family from residential treatment at Intermountain from 1990 – 2001.

These outcome measures would indicate that the developmental/relational approach contributes to positive outcomes for the children at *Intermountain*. A developmental / relational approach addresses children's violent behaviours as an expression of unmet needs, and treats children in residential care by the intentional use of intimate relationships, changing the child's experience of himself in relationship. The healing instrument is the relationship with staff. While progress can be measured in the child's meeting of goals on a treatment plan, and in objective behavioural rating as well as ability to remain within a family, the most compelling evidence of the power of relationships in a child's life is personal feedback. So I will leave you with the following quote from a young mother who was treated here at *Intermountain*:

> *I want to thank you for your love and respect that you showed me when I was young. You really made me feel safe and secure. That was a pretty rough part of my life and I'm thankful that you were there to guide me through it. It makes me strong for my family and it is a great example for me to keep in my mind when I'm raising my own family*

For further information about the model or about the work at *Intermountain* you can contact the author at www.intermountain.org.

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