THE USE OF STRATEGIC/SYSTEMIC METHODS
IN A RESIDENTIAL TREATMENT HOME

By

TIMOTHY PARE

B.A., Concordia University; Montreal, 1981

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS

in

THE FACULTY OF GRADUATE STUDIES
Department of Counselling Psychology

We accept this thesis as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA
April 1988

© Timothy Pare, 1988
In presenting this thesis in partial fulfilment of the requirements for an advanced
degree at the University of British Columbia, I agree that the Library shall make it
freely available for reference and study. I further agree that permission for extensive
copying of this thesis for scholarly purposes may be granted by the head of my
department or by his or her representatives. It is understood that copying or
publication of this thesis for financial gain shall not be allowed without my written
permission.

Department of Counselling Psychology

The University of British Columbia
1956 Main Mall
Vancouver, Canada
V6T 1Y3

Date April 28/88
The systemic orientation to behavioral change and the use of paradoxical interventions has been predominantly associated with the family therapy movement. Recently practitioners have been experimenting with the use of strategic/systemic methods in residential treatment centers, schools, and hospital inpatient settings. The literature suggests that these interventions may be ideally suited for oppositional or reluctant clients who resist cooperating in the treatment process.

This thesis provides a case study description of an adolescent treatment home which has developed a strategic/systemic approach to residential care. The implementation of a systemic perspective to residential treatment required substantial changes to traditional child care philosophy and practice. These changes are described and discussed and actual intervention examples are presented which help to illuminate this novel approach to residential treatment.
# TABLE OF CONTENTS

ABSTRACT .................................................. ii  
ACKNOWLEDGEMENTS ...................................... iii  

CHAPTER I - INTRODUCTION ................................. 1  
   NEED FOR THE STUDY .................................. 4  
   BACKGROUND TO THE PROBLEM ......................... 5  
      1) The Identified (IP) Patient ....................... 8  
      2) The Surrogate Parent Problem .................... 9  
      3) The Problem of Resistance ....................... 11  
      4) The Problem of Control and Discipline .......... 12  

CHAPTER II - LITERATURE REVIEW ......................... 17  
   TRADITIONAL THEORIES OF RESIDENTIAL TREATMENT ...... 17  
   PSYCHOANALYTICAL RESIDENTIAL TREATMENT ............. 18  
   BEHAVIORAL RESIDENTIAL TREATMENT ................... 32  
   GUIDED GROUP INTERACTION ............................ 37  
   THE RE-ED APPROACH .................................. 42  
   THE STRATEGIC/SYSTEMIC APPROACH ..................... 44  

CHAPTER III - METHOD OF STUDY ........................... 75  
   THE CASE STUDY AS A METHOD OF RESEARCH .............. 75  
   THE SINGLE CASE DESIGN ................................ 79  
   DATA COLLECTIONS .................................... 81  
   DATA ANALYSIS ....................................... 84  
   LIMITATIONS .......................................... 85  

CHAPTER IV - RESULTS .................................... 87  
   THE DEVELOPMENT OF A SYSTEMIC APPROACH .............. 87  
   RELATIONSHIPS ........................................ 91  
   RESISTANCE .......................................... 98  
   RULES AND CONSEQUENCES ............................... 101  
   THE PHYSICAL SETTING ................................ 104  
   THE STAFF ........................................... 105
I would like to thank all of the treatment home staff for their help and encouragement. Special thanks goes to Diane and Jacqueline for their valuable time.
Residential settings for the treatment of childhood and adolescent behavior problems were first developed in the early 1950's. Buno Bettelheim, Fritz Redl, and Moris Fritz Mayer are considered the founders of the residential or milieu approach to treatment (Whittaker, 1979). These theorists, who were all members of the psychoanalytic school, were of the opinion that clinical treatment, where a client is seen in an office setting once or twice a week, provided limited effectiveness for the child and adolescent population. In order to provide a more potent treatment approach they began to develop community based therapeutic environments. These therapeutic environments had a common goal of providing on-going, structured treatment in a setting removed from the child or adolescent's family (Klein, 1975).

Today the use of therapeutic environments for the treatment of childhood and adolescent problems is relatively widespread. There are currently numerous residential treatment approaches, each with their own particular philosophical orientation. With some of these approaches the theoretical foundations can be traced back to the original formulations of
the psychoanalytic theorists mentioned above. Other approaches have based their treatment philosophy on more contemporary ideas adopted from social interactive, educational or behavioral theories (Brendtro & Ness, 1983).

The systemic family therapy movement, which includes strategic and paradoxical therapy, has recently taken a leading role in the introduction of new methods for facilitating behavior change. Proponents of this novel approach have proposed a radically different view of problem formation and resolution (Watzlawick et al., 1974). This radically different view, which may be called the systemic orientation, challenges the traditional causal-mechanistic view of phenomena and suggests instead a theory of circular causality (Palazzoli et al., 1978). Circular causality assumes that present behavior is not determined by previous events in a cause-and-effect manner but instead is a product of an individual acting on and being influenced by a system of which he is a member.

Until quite recently the application of this new systemic orientation took place almost exclusively within the specialization of family therapy. Watzlawick and his associates at the Mental Research Institute (MRI) (1967, 1974), Palazzoli and the Milan group (1978a), and Haley (1963, 1976) are considered the leading proponents of the strategic/systemic
treatment of families. These therapists have used paradoxical interventions as the primary vehicle for introducing change within dysfunctional family systems. Paradoxical interventions are noted as the distinguishing feature of the systemic/strategic approach (Weeks & L'Abate, 1982).

Although the use of paradoxical interventions has predominantly been associated with the family therapy context, some researchers have investigated the potential for using these interventions under different circumstances. Numerous cases have been reported where specific behavioral problems, such as insomnia, obsessional thoughts and urinary retention, have been treated on an individual basis using various paradoxical interventions (Ascher, 1979; Solyom et al., 1972; Turner & Ascher, 1979; Kolko, 1984; Milan & Kolko, 1982). Stanton (1981b) reviewed the literature on paradoxical psychotherapy and reported that this approach has been used in a wide variety of cases. The presenting problems included, among others; alcoholism, anorexia and eating disorders, adolescent problems, anxiety, delinquency, depression, marital problems, phobias, schizophrenia and temper tantrums.

The latest innovation in the field of paradoxical psychotherapy is the application of paradoxical techniques in settings other than the clinician's office. Some creative
practitioners have been experimenting with the use of paradoxical interventions in residential treatment centers, schools, and hospital in-patient settings (Jessee & L'Abate, 1980; Bergman, 1980; Jessee et al., 1982; Williams & Weeks, 1984). In response to the promising results reported by practitioners of the systemic approach, coupled with a growing dissatisfaction for the more traditional approaches to residential treatment, a Vancouver based home decided to introduce some strategic/systemic methods into their treatment philosophy. The purpose of this thesis is to describe the use of these strategic/systemic methods and to provide examples of interventions that may or may not be effective within a residential treatment setting.

NEED FOR THE STUDY

There are two primary reasons why a study of this sort is needed at this time. The first reason has to do with the radically different perspective of problem formation and resolution proposed by the proponents of the systemic orientation. This new perspective must be investigated further in order to more fully develop a comprehensive theory of human behavior and change. The present study is a description of the practical application of this new approach and the theoretical concerns that become evident upon its implementation.
Secondly, a study of this sort is needed as a means for investigating potential improvements to the residential treatment field. Front line workers in a residential treatment home are faced with the extremely difficult task of trying to treat individuals who openly resist and actively sabotage the treatment offered to them. Techniques to increase the front line worker's effectiveness as a facilitator of change need to be developed in order to enhance the impact of the overall treatment environment. In summary, then, there is both a theoretical and practical need for the present study; from a theoretical standpoint, the consequences of applying systemic methods in a residential setting will be discussed, and from a practical standpoint, the potential use of new interventions in a residential setting will be investigated.

BACKGROUND TO THE PROBLEM

The treatment home which is the subject of this thesis has a mandate to provide residential treatment for up to seven adolescent girls between the ages of twelve and nineteen. The adolescents are expected to remain in treatment for three months, with a maximum stay of six months. However these are simply guidelines for suggested treatment duration and they are not rigidly enforced. There are eleven full time staff members employed at the treatment home (hereafter called Vanhouse).
Six people are employed as child care workers (usually three men and three women), two as overnight workers, two as family workers and a supervisor.

Prior to the introduction of strategic/systemic methods into the Vanhouse treatment plan the approach was predominantly relationship-based. This relationship-based approach, which had much in common with the Redl (1952) approach to be described later, relied on strong supportive relationships between staff and children to act as an agent for change. In addition the staff attempted to provide clear and consistent structure and used confrontation to set limits on the adolescents' inappropriate behavior.

Many of the Vanhouse staff expressed dissatisfaction with the approach to treatment that was employed prior to the introduction of the strategic/systemic methods. Open conflict between staff and residents was reportedly quite common and resistance on the part of the adolescent girls was the norm. At this time some of the staff began to investigate the strategic/systemic literature on problem formation and resolution. Two sources were of specific interest; Watzlawick's (1974) work with the Mental Research Institute and Palazzoli's (1978a) research with the Milan group.
The Vanhouse staff discovered through their investigation that, from a systemic perspective, the very idea of providing treatment to an individual removed from the family unit was countertherapeutic. From a systemic perspective an individual's symptomatic behavior is embedded in dysfunctional family patterns and therefore the ideal unit of treatment is the family itself (Slive, 1987). However, there are situations where the removal of the child from the family home becomes a necessity. For example, some family environments become highly destructive where violence, suicidal behavior or sexual abuse can severely threaten the child's well being. The Vanhouse staff decided that to provide effective systemically oriented treatment they would have to work in such a way as to avoid disempowering the adolescent or her family, and seek to involve them all in the solution to the family's problems.

Four specific issues of concern become apparent when attempting to provide treatment in a setting removed from the adolescent's family. These four issues, which are identified below, essentially represent some inherent complications or theoretical inconsistencies that arise when an attempt is made to treat adolescents in a residential setting. The challenge that faces any program is to come to grips with these issues and to provide solutions which are consistent with the overall goals of the treatment philosophy. The issues are as follows:
1) The Identified Patient (IP) Problem

The identified patient is the individual in the family who has been identified, usually by the parents, as the one who has the problem and needs to change. From a systemic perspective the "problem" is interactive, involving the whole family unit, and therefore it is epistemologically incorrect to identify any one individual as the "patient". By accepting the adolescent I.P. into the home for treatment the staff are implicitly agreeing that the solution to the family problems may be resolved by "curing" the adolescent in isolation from family interaction. Therefore the attempted solution to the family problem, i.e. placing the child in care, adds to the problem by strengthening the idea that one person is at the root of the problem.

An issue that is associated with the I.P. problem, and which has been identified by Slive (1987), is that of "treatment sabotage". Now that the I.P. has been isolated as the cause of the family problem the parents turn to the treatment staff and ask for a cure. However, paradoxically, if the staff succeed in a "cure" then the parents feel that they themselves must somehow be incompetent as caretakers. There are two solutions that the family may attempt to resolve this
problem of appearing incompetent. Both solutions involve an attempt to sabotage treatment.

With the first solution the parents withhold important information that might help the staff in their treatment plan or they refuse to accept that any positive behavioral changes have occurred while in treatment. By not cooperating with the staff and by refusing to acknowledge or encourage positive signs of change the parents protect their identity as "good parents". The second way that treatment may be sabotaged involves the loyalty of the I.P. The I.P., who generally has a great amount of hidden loyalty to her parents, may resist improving her behavior to avoid making her parents look like failures. This loyalty likely includes resisting whenever staff take on a role that is similar to their parents' role. These sabotage attempts are good examples of how the family hangs on to the status quo and their shared world view (Minuchin, 1974).

2) **The Surrogate Parent Problem**

This second theoretical problem which is associated with residential care has been examined well by Perry et al. (1984) in their article, "Separation and Attachment: A Shift in Perspective". Traditional approaches to residential treatment
stress the importance of developing strong bonds between staff and children as an active agent for change (Bettelheim, 1974; Jones, 1980; Brendtro & Ness, 1983). If the goal from a systemic perspective is to facilitate problem resolution within the family unit, then bonding between the staff and adolescent may, to some extent, be countertherapeutic. The rationale for this is that if the adolescent turns to the staff to meet their intimacy needs then the staff may act to block the interaction that might have occurred between the family and the adolescent.

The fact is that a child care worker is not, and can never be, the child's parent. He or she is not a simulation, artificial or imitation parent. Unfortunately many adolescents in care are developmentally at a stage where given the opportunity they will "attach" themselves to the staff members and, in turn, "detach" from their parents and families. As Perry et al. (1984) state, adolescence is a time when separation and attachment issues surface and the result is often a disturbed, turbulent environment. This unstable situation, given time, will more than likely resolve itself as the adolescent develops an identity separate from the family unit. However, it is precisely at this time, when the adolescent is beginning to tackle the developmental identity issue, that the community resources become involved and risk complicating or postponing the resolution of this issue.
The point to be made here is that placement may exacerbate the "problem" by disturbing the natural process of separation and attachment that occurs during an adolescent's development. For this reason residential staff must take a long and hard look at their own behavior and identify how they can best facilitate the natural process mentioned above and avoid any action on their part that may contribute to the problem.

Perry et al. (1984) give examples of how residential treatment interventions disempower the family as a unit by creating a struggle between the family, adolescent and staff. The adolescent is said to be "triangulated" in a process where the staff and the family are essentially pulling in opposite directions. As we can see this "surrogate parent" problem is a serious theoretical concern for any residential treatment home.

3) The Problem of Resistance

The third major obstacle to effective treatment in a residential setting has to do with the phenomenon of client resistance. This issue, which has a long history within the mental health field, is especially relevant when dealing with reluctant clients. The residential setting is a unique treatment environment where the client not only resists
treatment but often does not even acknowledge that any problem exists in the first place.

Recognizing that even under the best of circumstances people resist changing their behavior, it's no surprise to discover that a reluctant client, who is also an adolescent and is likely experiencing a life crisis, provides an immense challenge to those who are in the position of administering treatment. Much of the child care worker's energy and thought is taken up by this task of dealing with resistance.

Associated with the resistance problem is the difficulty in "reaching" the adolescent who lacks insight into her problem situation. This incapacity may be due to poor language skills, conceptual skills, or repression.

4) The Problem of Control and Discipline

The last issue of concern arises from the necessity for the staff to manage the behavior of the residents. At the very least the staff must have enough authority to control behavior that threatens the safety of the adolescents in the home. If the staff are required to put themselves in a one-up position when it comes to house rules, then their therapeutic role within the home is clearly affected.
According to Dahms (1978);

It is a maxim in residential programs that effective treatment needs to be preceded by effective control; that no treatment is really possible unless the disturbed, delinquent, or disorganized behavior of the client population can be made responsive to staff authority and control. (pg. 336)

The problem here is that traditional approaches to residential treatment generally employ a linear approach to resident behavior management. In other words, if a resident fails to cooperate with staff requests, more "force" is applied to overpower the adolescent and gain their cooperation. Dreikurs (1964) has shown how easy it is to become involved in power struggles with difficult young people. When staff become involved in power struggles with residents the adult is likely to display hostile or aggressive behavior. Such counter aggression is always counter-productive because it validates the adolescent's existing perception of the adult as a negative person.

This control issue can be summarized in the form of a question; how can staff exercise adequate control over
The four issues mentioned above are presented as roadblocks or challenges to the effective treatment of adolescents in a residential treatment setting. The new systemic approach introduced into the Vanhouse treatment program is an attempt to tackle these roadblocks and provide a more effective treatment environment. In order to accomplish this two major changes were introduced into the treatment program. The first change involved providing family therapy sessions for the adolescents and their respective families. The purpose for this change was to involve the whole family as much as possible in the process of change. The second major change was the use of strategic/systemic methods as the predominant mode for providing on-going treatment within the residential setting.

This thesis is a descriptive study of the use of these strategic/systemic methods in the Vanhouse treatment setting. The study is a qualitative, rather than quantitative, analysis of the interventions utilized and the associated theoretical issues that become evident upon their implementation. The specific questions addressed by this thesis are:
1) How were the strategic/systemic interventions formulated and delivered within the residential setting?

2) Based on the author's clinical judgement as a participant observer in the home, which of the various interventions utilized appeared to be most successful and for what reasons?

3) What are the significant contextual variables associated with the implementation of these interventions in the residential setting?

4) What are the comparative benefits and drawbacks of using strategic/systemic methods, as opposed to traditional methods, in a residential setting?

The method of study chosen to answer the above questions was the case study approach. According to Yin (1984), the case study method is the research method of choice when a "how" or "why" question is being asked about a contemporary set of events, over which the investigator has little or no control. The case study takes a holistic view of a phenomenon and attempts to illuminate the significant variables and make qualitative statements concerning the relationship between them.

The present thesis is an example of a single-case research design. The evidence presented is based on three different sources of data collection; documentation, interviews and information obtained through the participant observation role. The author of the thesis was employed for six months as a part-time child care worker in the home. This participant-
observation role provided the author with a first-hand, in-depth look at the approach to residential treatment that was developing at Vanhouse. Chapter three of the thesis provides more information on the case study as a method of research.

The following chapter provides a thorough review of the traditional approaches to residential treatment as well as the strategic/systemic approach to problem formation and resolution.
TRADITIONAL THEORIES OF RESIDENTIAL TREATMENT

In this section four distinct theories of residential treatment will be discussed; the psychoanalytic, behavioral, guided group, and re-education approaches. Once these four theories have been discussed, the significant ingredients that make up residential treatment will be isolated and examined separately. It is important to keep in mind that the purpose of this review, of the traditional approaches to residential treatment, is to understand the context into which the systemic-strategic methods were introduced.

Morse, Cutler and Fink (1964) report that "many child care workers are atheoretical naturalists" who base their work on their own personal theories and who are often quite successful at their job (Morse, Cutler, & Fink, 1964). In some treatment centres with a stated orientation, the workers rely more on their personal bias to treatment while outwardly complying with the organization's expectations. Since child care workers tend to follow their own implicit theories, it becomes an enormous task to mold a service organization to comply with a particular philosophical orientation (Brendtro & Ness, 1983). Keeping
this point in mind, let us examine the first traditional approach; the psychoanalytic.

PSYCHOANALYTICAL RESIDENTIAL TREATMENT

The pioneers who first developed a residential or Milieu approach to treatment for troubled children were all strongly influenced by psychoanalysis. These pioneers included Bruno Bettelheim (1950, 1955, 1967, 1974; 1948 with Emmy Sylvester), Fritz Redl (1957 with David Wineman, 1959, 1966), and Moris Fritz Mayer (1960, 1971 with Arthur Blum). These three prominent theorists attempted to apply basic psychoanalytic principles to the child's total living environment.

Bruno Bettelheim's work, as well as being influenced by psychoanalytic writings, was influenced by his experience as a prisoner in the Nazi concentration camps of Dachau and Buchenwald (Whittaker, 1981). From his prison experiences, he was able to see how strong the human spirit can be in overcoming even the most degrading of environments.

During the years from 1944 to 1973, he was the director of the University of Chicago's Sonia Shankman Orthogenic School for emotionally disturbed children. His work at the Orthogenic school is reported by himself in books such as "Love is Not
Enough" (1950), "Truants from Life" (1955), "The Empty Fortress" (1967) and "A Home for the Heart" (1974). Whittaker (1981) describes Bettelheim's work as follows:

While there is much value and sheer brilliance, it is a difficult approach to put into operation. To be sure, his clinical accounts are fascinating descriptions of what disturbed behavior is like, though in my judgement, many are based on false assumptions and sheer speculation about the origins of childhood disorders. (1982 p. 47)

Although Bettelheim's work may not be considered a comprehensive treatment approached in its own right, his influence had a great impact on the development of a milieu approach to treatment. His work reflects a passion for detail with every aspect of the treatment environment considered for its therapeutic effect. The development of what he called "total therapy" took into account the rules, routines, activities, staff/child interactions and architecture of the treatment environment (Bettelheim, 1974).

Another important contribution introduced by Bettelheim was his recognition of the importance of the front line workers. This realization, of the considerable therapeutic
impact imparted by workers in their day-to-day interaction with children, is most evident in his later writings—especially "A Home for the Heart" (1974).

The theorist whose name is most commonly associated with the psychoanalytic approach to residential treatment is Fritz Redl. Redl's book, "Controls from Within" (1952) could be considered the basic textbook on residential treatment. Although his work is labelled psychoanalytic, Redl's descriptions of staff/child interaction cut across theoretical boundaries and helps to uncover the basic elements of residential treatment. His approach has much in common with the common sense, experience-based approach that developed at Vanhouse prior to the introduction of systemic/strategic methods. For this reason, a thorough coverage of the Redl approach is provided.

The cornerstone of the Redl approach is a view of childhood pathology as an indication of a poorly functioning ego (Redl, 1952). Ego is that part of the personality which keeps us in touch with reality and with which we regulate our impulse expression so that it is within the bounds which such a reality dictates. Redl suggests that the child referred for treatment typically is unable to adequately deal with the numerous impulses which continually challenge the ego. For
example, such children are unable to handle fear, anxiety, or insecurity of any kind without breakdown into disorganized aggression (Redl & Wineman, 1951). The aggression leads to guilt and since the child's ego is weak and unable to deal with the guilt, a cycle begins where guilt leads to aggression, aggression leads to guilt, etc. In Redl's extensive work with children, it became clear to him that the "individual treatment process", seeing the child once or twice a week for an hour at a time, was relatively ineffectual compared to what might be provided in a treatment home. Also, and most importantly, he realized that the treatment provided by the home should be ongoing and as such be primarily provided by the child care staff who have day-to-day contact with the children. In this respect, as well as many others, Redl was well before his time, bringing the treatment to its grass roots level and thereby providing the children with a powerful environment for change. Redl describes the weakness of the individual treatment process in his characteristically flavorful prose:

No matter what geniuses we may be and what flawless job we may have performed in the treatment of a child's anxiety neurosis in our sessions, how can we get any place if the same child spends 23 of the 24 hours of his waking and sleeping day in a framework which is so full of traumatic situations? How can we
help a child if soon after his meeting with us, he steps into a world regimented by the compulsive picayunishness of suppressive roles and routines narrowed by a programless exposure to boredom, sprinkled with the over-stimulations coming from selective contagion-initiators in his group, peppered with the scenes of sadistic punishment and sentimental teacher pet cultivation, and punctured by nothing but wordy speeches and lectures from child-disinterested representatives of societal demands? (1952, p.40)

Faced with the inadequacy of the individual approach and the severity of the so called "ego impairment" of the children in need of treatment, Redl developed a treatment process which included the total environment of the youngster. This "total environment" provided by Redl has as its basic goal the strengthening of the ego through various ego-supportive strategies. Redl (1952) classifies four basic modes of ego support; 1) the ego support by the impact of the design of the total environment, i.e. physical lay out, policies, rules, 2) the ego-supportive role of activity and program structures, 3) the techniques to handle day-to-day behavior, or what Redl calls "surface behavior", and 4) the ego-supportive impact of the whole strategy of handling their own life experiences.
With ego support and strengthening as a basic treatment goal, Redl began to formulate his "total treatment design". The actual pioneering attempt to create a residential treatment milieu had been made earlier by August Aichorn and is described in his book "Wayward Youth" (Aichorn, 1935). However, for our purposes, Redl's approach offers a more in-depth account of the milieu approach. His total treatment approach requires that every aspect of the design be considered for its contributory therapeutic impact. This means that the physical layout of the home, the housekeeping policies, the relationship between staff members, and all the way down to the particular way meals are served, is taken into account for its therapeutic influence.

A key element of the Redl approach is providing the children with a program that satisfies their needs to have "fun". In other words structured activities, games and crafts are not seen simply as time-filling programming but as an integral part of the therapeutic process. The staff communicates through their encouragement and complete acceptance of the children's "fun activities" that they care about them and are there to support them in their need gratification. Staff are directed at all costs to avoid any messages of hostility towards the children's "fun activities". When interference must be used, it is the "reality limitations" attitude that must be conveyed.
It is important to note at this point that the clients that Redl developed his treatment philosophy for were boys between the ages of 9 and 12 and therefore the structures and programming of the home is tailor-made for that population. However, this does not in any way mean that Redl's ideas and techniques cannot be modified so as to be effective with another population of children.

This brings us to a most crucial area of treatment philosophy; the relationship between staff and children. Just as the relationship between client and therapist in the individual or family counselling setting is a lively and controversial issue, so it should be within the residential treatment context. However the literature on residential treatment and relationship is remarkably scarce when you consider how important this issue is to the overall treatment design. Most of the literature from the different approaches seems to suggest that a nurturing, supportive relationship is a key ingredient of therapeutic success (Bettelheim, 1974; Jones, 1980; Brendtro & Ness, 1983), but few go on to describe that relationship or offer a rationale to explain its therapeutic effect. This issue will be described in detail at a later time, for now let us return to Redl and his thoughts on staff-child relationship.
Redl emphasizes that an accepting, affectionate relationship between staff and children is essential, but stresses that the staff must also play the role of "protector". The adult plays the role of protector in four significant areas; protecting the child from other children, from himself, from outside interference and from potentially dangerous situations. Interference to protect a child from his peers is used sparingly and only in those situations where aggressive behavior reaches a potentially harmful level. Otherwise the children are left to themselves to settle inter-group tension and conflict. This non-interference strategy is in agreement with the systemic approach to interactional problem resolution which will be discussed in a later section.

Protecting the children from themselves is an important issue in treatment that, as we shall see later, becomes a central concern in the Vanhouse treatment philosophy. Children in treatment, even those with what Redl calls weak-ego development, are acutely aware of when their behavior crosses the boundary into the inappropriate region. Redl believes that if the staff, for whatever reason, fail to provide limits to curb this extreme behavior the child will react in a somewhat paradoxical manner by escalating the inappropriate behavior as an invitation for more control by the staff (Redl, 1952). In other words, the child in seeking to find the limits of his or
her power will progressively escalate their behavior until effective limits are placed upon them. This dynamic is sometimes referred to as "testing" by child care workers and the new staff member is constantly "tested" in a methodical and persistent manner by the probing children. Once the child feels confident that a particular staff member will consistently provide protective limits, the probes, via inappropriate behavior, subside and the child appears to relax and displays more conflict-free behavior. Redl (1952) notes that not only does the child become more aggressive when protective limits are not established but he/she will react negatively afterwards to that particular staff who missed their function of protective interference.

Some of these "protective functions" described by Redl (1952) are what most people commonly refer to as discipline and they take a central role in Redl's treatment approach. Whenever Redl's staff interferes with a child's behavior they are cautious to frame the interference as protective and caring, as opposed to punishing which is associated with disapproval. This attitude towards inappropriate behavior is what Redl (1952) believes clearly distinguishes his treatment approach from educational programs. Educational programs commonly reward positive behavior and restrict or punish behavior which is seen as inappropriate or undesirable
In Redl's approach undesirable symptoms are tolerated with an attitude of acceptance, coupled with an expectation for eventual change. The message which Redl suggests should ideally be transmitted to the children can be summarized: "We like you, we take you the way you are, but of course in the long run we'd like you to change". (Redl, 1952, p. 59)

There is a fine line between "permissiveness" on the one hand and "symptom tolerance" on the other. The attitude of tolerance allows the symptoms to come out in the open, to be exposed, so that they can be manipulated and used for treatment purposes. A permissive attitude, on the other hand, lends itself to misinterpretation as the child might assume that the staff has taken a position of indifference to the inappropriate behavior or is actually encouraging the child to act out. The creation of an appropriately tolerant atmosphere is a serious strategic issue, one which creates much controversy and discussion in any residential treatment setting.

We can view limit setting, or what Redl (1952, p. 57) calls "limit interference", as one type of interaction which occurs between staff and children during treatment. Another interaction, of a more positive kind, is the display of affection and warmth. Redl believes that a heavy dose of
affection is required to carry out effective treatment and that this affection should be distributed evenly amongst the group. It appears that the ideal relationship between staff and child that Redl envisions is very similar to Carl Rogers' ideal relationship between therapist and client (Rogers, 1961). Redl stresses that element of the relationship which Rogers calls "unconditional positive regard", using the term "tax-free" love instead (Redl, 1952, p.61). The following quote summarizes Redl's position on the relationship between staff and children;

The children must get plenty of love and affection whether they deserve it or not; they must be assured the basic quota of happy recreational experiences whether they seem to have it coming or not. In short love and affection, as well as the granting of gratifying life situations, cannot be made the bargaining tools of educational or even therapeutic motivation, but must be kept tax-free as minimum parts of the youngster's diet, irrespective of the problems of deservedness. (Redl, 1952, p.61)

One of the most valuable contributions provided by Redl is his detailed descriptions of specific techniques for handling problem behavior. Redl refers to these techniques as "the antiseptic manipulation of surface behavior" (Redl, 1952,
Many of the 17 techniques described by Redl are used by child care workers, as well as parents, on a "common sense" or "common knowledge" basis. Redl goes one step further and provides theoretical support for these interventions and suggests when and how to most effectively apply them. The "antiseptic" that Redl refers to suggests that, whatever the goal of the intervention, the clinician or front line worker must first be concerned that the intervention is not counter-therapeutic. In other words, although there is a definite requirement for the staff to provide limits it must be carried out in such a manner than any therapeutic gains that have been made thus far are not destroyed. The loss of established rapport between staff and child and the creation of a traumatic episode are two examples of the potentially counter-therapeutic effects of staff interventions.

Due to the constraints of space a thorough coverage of Redl's various interventions will not be undertaken. However since Redl's work offers the only in-depth analysis of the day-to-day interactions between staff and children and since these interventions are often considered the core component of any residential treatment approach, a description of some of the key interventions follows.
Interventions are not simply techniques to provide a safe and manageable environment, they are also important ingredients in the therapeutic process. One of the most interesting and deceivingly simple techniques is called "planned ignoring" (Redl, 1952, p. 158). Planned ignoring essentially means that the staff member avoids interfering in behavior that may on the surface appear inappropriate. Child care workers with considerable experience become very adept at sizing up a situation quickly and deciding if their interference will help to solve the situation or simply exacerbate it. The difficult part, of course, is to know when to let something go and when to interfere. A typical example might be the case where a frustrated teenager returns from a difficult day at school and comes stomping in the house glaring at anyone who crosses his/her path. Depending on a number of factors, such as; who the child is, who else is in the house and the rapport developed between staff and child, the staff member may decide to ignore the behavior or, on the other hand, the staff may decide to intervene immediately. By ignoring the behavior the staff avoids becoming part of the problem. This technique of planned ignoring has a similar rationale to the problem resolution proposed by Watzlawick et al. in their book, "Change" (Watzlawick, Weakland & Fisch, 1974). Watzlawick refers to faulty interference as "when the solution becomes the problem" (Watzlawick et al., 1974, p. 31).
Another intervention of significant interest is what Redl refers to as "interpretation as interference" (Redl, 1952, p.178). Redl describes it as the attempt to help a child understand the meaning of a situation which he has misinterpreted, or to help him grasp his own motivation in an issue at hand. The on-going treatment provided by the Redl approach requires the staff member to intervene through "interviewing" the child whenever a significant incident occurs. Redl classifies six types of interviews under the following categories; "the rub-in interview", "guilt-squeeze interview", "expressional interview", "interpretation interview", "counter-distortional interview" and the "group interview" (Redl, 1952, p. 254). These interviews function to defuse disruptive behavior and therapeutically act as a means to support and strengthen the child's weak ego. Each of these interviewing styles are familiar to child care workers and other professionals working with children who have had considerable experience in the field.

In summary, we can see that one of the most unique aspects of the Redl approach is the use of the total treatment design to influence behavioral change. The treatment environment is viewed as a shaping tool which can be manipulated either to "soften or lure out symptomatic behavior" (Redl, 1952, p. 307). Treatment takes place in an on-going fashion with the display
of pathological behavior seen as an opportunity for the staff to provide an appropriate treatment intervention. Redl's "techniques for the manipulation of surface behavior" provides us with a good description and rationale for many of the interventions which child care workers use both in the psychoanalytic tradition and many of the other treatment approaches. Redl's micro-analysis of the daily interaction between staff and child suggests the paramount importance of the relationship between these two parties.

It is important to note at this point that the psychoanalytic label associated with Redl's work is perhaps somewhat of a misnomer. Redl's work is psychoanalytic in the sense that he uses psychoanalytic terms to describe the maladaptive behavior displayed by children in care. However his interventions are not "traditionally psychoanalytic" and as such they stand on their own, independent of any label or school of psychology.

BEHAVIORAL RESIDENTIAL TREATMENT

The introduction of behavioral concepts and techniques to the milieu approach came at a much later date than those of the psychoanalytic tradition. Like Redl the behaviorists believed that to have a significant treatment impact the therapy should
be provided in an on-going manner, not by a psychotherapist who is both physically and experientially removed from the child's natural life milieu (Whittaker, 1979). In the early 1960's a group of psychologists and educators at the University of Washington first attempted to apply the principles of behavior analysis in a natural setting. These initial studies examined the effects of teacher attention in maintaining problem behavior in children. In a series of experiments, the investigators demonstrated that such diverse behaviors as a regressed crawling (Harris et al., 1964), socially isolate behavior (Allen et al., 1964), excessive crying and whining (Hart et al., 1964), and excessive scratching (Allen & Harris, 1966) were directly controlled by their immediate consequences in the environment - in this case the attention of adults. By selectively withholding and dispensing social reinforcement the experimenters were successful at altering the above behaviors. Encouraged by this success, a number of school programs, treatment centers, and group homes adopted behavior modification programs. Whittaker (1979) points out that although individual behaviorists differed in style and emphasis their efforts were founded on the following agreed-upon principles:

1) A child's psychological nature is his behavior; directly observable and measurable actions constitute the sum and substance of personality. The behaviorist rejects the notion of inner
personality - states such as id, ego and super ego.

2) Behavior is largely controlled by the environment and, in the case of operant or active behavior, is either strengthened, maintained, or diminished by its immediate effects on the environment. Therefore if the reinforcers for any given behavior can be identified and brought under control, the behavior itself can be similarly controlled.

3) The symptom of the troubled child is the entire problem; it is not simply an external manifestation of some underlying disease process, psychoneurosis or character disorder. If the acting out of the delinquent, or the bizarre behavior of the psychotic child, is stopped, then the basic problem of delinquency or psychosis has been solved (taken from Whittaker, 1979, p. 57-58).

From a practical standpoint behavior treatment is inviting in that there is no need to analyze the so-called "deep seated" contributors to an individual's current pathological behavior. The behaviorist simply takes the problem behaviors as they stand and looks for clues to how these behaviors are elicited and maintained within the child's environment. As Whittaker (1979) points out, treatment usually involves four stages; 1) identifying and specifying the problem behavior, 2) determining the controlling conditions; patterns of reinforcement, learning history, environmental factors, 3) specifying the pro-social behavioral goals, 4) applying any number of behavioral techniques, either singly or in combination, followed by a precise evaluation of progress.
A typical example of behavior modification in a residential setting involves the use of a "point system" which is monitored daily. A number of behaviors are identified which are considered either desirable or undesirable and a reward system is established contingent on these behaviors. At the end of the day, the accumulated points are tabulated and some reward such as money or extra privileges is given to the child. In some programs there is the contingent use of both positive and negative reinforcers to simultaneously accelerate desired behaviors and decelerate undesirable ones.

One of the most noteworthy behavioral milieu treatment programs for disturbed children was described by Phillips in the early 70's (Phillips et al., 1973a). The goal of the program, called Achievement Place, was to teach youths the basic skills to help them avoid problems with their families, teachers and the law. The youths selected for the program lived with a professionally trained couple, "teaching parents", who interacted closely with the youth and closely monitored their progress in school, on home visits, and within the treatment environment. The youth in Achievement Place progressed through a series of behavioral programs which gradually allowed them more privileges and freedom as behavior improved. An interesting finding which is especially relevant to this thesis is that an attempt to replicate Achievement
Place in another home proved to be a failure. The explanation offered for this failure is a lack of social reinforcement in the second home. Social reinforcement apparently occurs when an intimate relationship develops between staff and youth in the process of dispensing points as reward. Without the development of this kind of relationship the reward system fails to encourage progressive change in the youth. Phillips reports that the point system could work at peak effectiveness only in the context of a warm, open and giving interaction; "Many clinical colleagues have told us all along that 'relationship' is an essential component of any therapy. We are now convinced that they are right." (Phillips et al., 1973a, p. 107).

This question of relationship and how it contributes to change is a central concern in this thesis. Although it is clearly impossible to determine the relative treatment effects of "relationship" between staff and child as compared to the contribution provided by techniques, it is important to keep in mind that these two variables likely have an interactive effect. As mentioned above, even the behaviorists, who usually focus on reinforcement schedules and other behavioral techniques, concede that without a close interpersonal relationship, successful treatment is unlikely.
The behavioral approach to residential treatment is more standardized and systematic than most other treatment programs. The goals and techniques for treatment are often clearly laid out and as a result the approach lends itself particularly well to comprehensive evaluation. Problems that have been encountered include program design and staff attitudes and reactions (Browning & Stover, 1971). It appears that difficulties arise when one attempts to balance a program stressing equally the acceleration of desirable behavior and the deceleration of undesirable behavior, and at the same time offer continuous positive reinforcement to elicit increasingly complex behaviors. Staff often report that they find behavior modification techniques "unnatural" and as a result their attitudes toward the program undermines its effectiveness (Whittaker, 1979). Browning and Stover (1971) found limitations to the generalization of effects and in providing a treatment environment that gradually approximated the home setting. Their conclusion was that one should not assume generalization but, rather, should work to ensure that what is learned in one setting is elicited and maintained in another.

GUIDED GROUP INTERACTION

The third major treatment approach to discuss is Guided Group Interaction. This approach stresses the importance of
viewing the child as part of a social system within the treatment institution. As with both the psychoanalytic and behavioral approaches the guided group interaction proponents argue that treatment effectiveness is highly dependent on the quality of the day-to-day interactions the child has with those individuals who share his life space. Most importantly, the guided group interaction proponents stress the overwhelming influence of the child's peer culture on his or her behavior (Glasser, 1969; Rose, 1972; Strain, 1981). To encourage significant treatment gains, the guided group approach (G.G.I.), utilizes the powerful influence of the peer group, acknowledging it as an integral part of the treatment process.

Goffman's (1962) classic study of institutional life acted as a catalyst for the G.G.I. approach with the description of how institutional structure and processes were often contradictory to the formally stated treatment objectives of the institution. Another sociologist, Howard Polsky, also published a study which raised serious concerns about the effectiveness of institutional treatment for delinquent youth. In Polsky's (1962) study, he acted as a participant observer in the cottage institution of Hollymeade. This institution's treatment depended primarily on almost daily individual therapy, with psychiatrically trained personnel, which took place in an office setting physically removed from the culture.
of the cottage. The cottages were supervised by "cottage parents" who were minimally trained and effectively removed from the clinical decision-making process of the institution. Polsky's results suggested that the most powerful influence on the adolescent's behavior was not the individual treatment sessions or the interaction with the cottage parents but was in fact the delinquent subculture thriving within the institution. He discovered that the cottage had its "leaders", "status seekers", "con-artists", "isolates", "bush boys" and "scapegoats", and that a power structure existed based on intimidation through physical coercion, toughness and a code of silence. Polsky explains the weakness of the institutional experience;

In the family, the child is not exposed to a father and a mother, but to their interaction, their "family culture". In the institution, the youngster is barred from extensive interaction with professional staff culture, yet he is expected to achieve the latter's goals. In the cottage, hard-pressed cottage parents are outnumbered by delinquent youths. Many boys improve in spite of the negative peer pressure; others fail because of it. (Polsky, 1962, 149)
The guided group proponents recognized this overwhelming subcultural influence and decided to structure their treatment using the peer group as an integral part of the therapeutic endeavor. Pilnick (1971) defines the approach as follows:

Guided Group Interaction is a process of group treatment which directs the dynamics and strengths of the peer group toward constructively altering and developing the behavior of the group members.

Empey and Lumbeck (1972) state that the basic objectives of G.G.I. are to question the utility of persistent delinquency, to provide behavioral alternatives, and to provide recognition for a youth's personal reformation and for his willingness to help reform others.

The guided group approach attempts to use the peer group to develop positive pro-social values and reinforces conformity by strongly sanctioning behavior that violates group norms (Whittaker, 1979). The group itself is often given decision-making power to determine what privileges and responsibilities each of the members deserve. Members of the group are usually required to attend highly structured group sessions where each of the participants reports on how they are "handling the situation" and receives feedback from the other members.
Intense group dynamics are generated that must be monitored closely by a staff who acts as a group leader.

Typically the group members deal with the following issues; low self-esteem, inconsiderate of others, authority problem, misleads others, easily misled, aggravates others, easily angered, stealing, alcohol or drug problems, lying and fronting (trying to be something you are not; clown, tough guy, dumb-bell) (Vorrath & Brendtro, 1974). Honesty, of course, is highly valued and confrontation is implicitly encouraged by the group leader. Vorrath and Brendtro (1974) described the group leader's primary verbal behavior as "questioning" and stimulating the group toward the solution of problems. The sessions follow a strict agenda; reporting problems, awarding the meeting, problem-solving and leader summary. Due to the potentially explosive atmosphere that can be expected when a group interacts at an intense level, the group leader must be skillful and knowledgeable of group dynamics. Losing control of the group or misreading an individual's responses can have serious detrimental effects on group members.

The question of the relative effectiveness of guided group approaches as compared to other programs remains unresolved. Stephenson and Scarpitti (1974) reviewed several institutions and community based guided group programs and found that the
guided group graduates fared somewhat better than the traditional reformatory graduates, but not as well as youths on parole. A common criticism of the guided group approach is that to a large extent it seems to be based on personality rather than method (Whittaker, 1979). In other words, programs with a charismatic leader may be successful simply because the strong personality of the leader acts as an agent for change. Whittaker suggests, however, that for older adolescents whose delinquent behavior originates and is maintained in the peer group, Guided Group Interaction presents a potentially powerful technique for going to the heart of the delinquent's subculture and orientating it in a positive direction.

THE RE-ED APPROACH

The fourth, and last treatment approach to be examined is the Re-ed concept introduced by Hobbs (1967). The Re-ed program is an American adaptation of the "educateur" role that was common in Western Europe. Re-ed is a combination of group living and special education in small, community based programs. The acquisition of new life skills and the enhancement of the child's learning abilities are basic goals for this approach. Staff usually have a background in classroom teaching and are trained in life-space interventions. Re-ed's focus on education aims to stimulate the child in his
environment and to re-activate his natural ability to acquire new skills and knowledge (Brendtro & Ness, 1983). Hobbs (1964) explains that the learning bias of the Re-ed approach is based on an assumption that the child who is experiencing problems needs to learn how to learn. The core components of the Re-education process are, according to Hobbs; developing trust, gaining competence, nurturing feelings, controlling symptoms, learning middle class values, attaining cognitive control, developing community ties, providing physical experience, and knowing joy.

A criticism that may be levelled against the Re-ed program is that although its proponents are strong on accenting the natural strengths of children and present an optimistic scenario, they fail to provide concrete information on how to deal with problem behavior and how to "reach" the severely disturbed child. The teacher-counsellor, who appears to be the mainstay of this approach, is described as "a decent adult; educated, well trained, ... a person of hope, quiet competence and joy". (Hobbs, 1964, p. 15). Every treatment program would hope that their staff meet this description, but is the exposure to "decent" adults a potent enough force to significantly alter the entrenched behavior problems of children in care? Furthermore, although the Re-education process is likely a positive agent for change, does one not
require the cooperation and willingness of the child to partake in educational experiences?

In the development of the Re-ed program, the Re-ed schools have gravitated towards behavioral approaches to treatment. However, Hobbs in reviewing the first 20 years of project Re-ed states that the behavioral component of the program should not be over-emphasized. He states that behavioral modification "... pays insufficient attention to the evocative power of identification with an admired adult, to the rigorous demands of expectancy stated and implicit in situations, and to the fulfillment that comes from the exercise of competency" (as cited in Brendtro & Ness, 1983). With the de-emphasis of behavioral techniques, the problem still remains of how to motivate and limit the behavior of troubled youth. In many respects, one questions whether Re-ed can be classified as a treatment approach as it appears to belong more to the special education field. Nevertheless, Hobbs' philosophy has contributed to the general field of residential treatment by stimulating discussion and drawing attention to community based treatment possibilities.

That completes the review of the traditional approaches to residential treatment. Each of the above theories has its own view of human nature and change. This view if reflected in the
strategies and structures that each treatment approach adopts in an effort to enhance therapeutic change. In the following section, the strategies suggested by the family therapy movement with their corresponding view of human nature and change will be reviewed and contrasted with the traditional approaches outlined above.

THE STRATEGIC/SYSTEMIC APPROACH

In this section, some of the strategies and theory related to the strategic/systemic approach* will be reviewed, followed by a review of the literature which deals specifically with the use of strategic/systemic methods in treatment settings.

As was mentioned earlier, much of the literature on paradoxical psychotherapy originated and was used predominantly by family therapists working with the family as a unit. Working with the family as a unit requires that the therapist adopt an interactional perspective; viewing each family member as part of a larger system which influences his or her behavior. Some paradoxical therapy has been used with individuals, both in a clinical setting and within residential, school or hospital settings. Weeks and L'Abate (1982) refer to three levels of paradoxical intervention; the individual, interactional and transactional or systemic. In the first
level, the paradoxical intervention is directed toward only one person or one member of the family. The second level or interactional level involves the direction of the intervention at all the members of the system, but as individuals. This level provides interlocking paradoxical messages, which as Weeks and L'Abate (1982) point out, focus on dyadic interactions. The third level of intervention is the transactional, where the paradoxical message is directed at the entire system in an attempt to capture the dilemma that faces the family or group.

This thesis is primarily concerned with the use of individual paradoxical interventions with adolescents in a residential setting and therefore emphasis will be placed on the first category identified by Weeks and L'Abate (1982). It is important to note that paradoxical interventions directed at individuals may involve and refer to other people, but they are directed at only one person at a time. When formulating a paradoxical message that is to be directed at an individual it is essential that one adopt an interactional perspective, taking into consideration other individuals that may be contributing to the maintenance of the problematic behavior (Watzlawick et al., 1974).
The distinction between first and second-order change provides a good introduction to the strategic/systemic view of change and problem resolution. Watzlawick et al. (1974), discuss two levels of change based on the work of a cyberneticist (Ashby, 1956), who coined the first and second-order change. First-order change refers to change within a given system. In this level of change, the system remains intact while some elements within it undergo a change in quantity. First-order change involves applying old solutions to new problems. If a problem becomes evident that has been solved in the past with some solution, the solution is applied again. If the problem fails to be resolved then "more of the solution" is applied in a linear or step-wise fashion (Weeks & L'Abate, 1982). A relevant example would be the progressive withdrawal of privileges for a resident in a treatment home who continues to misbehave. More of the same, in the form of punishment, is used in an attempt to solve the problem.

Second-order change is a change of the system itself. The system is said to move to a higher level of functioning and the body of rules which governs the group is altered to fit the new structure. Second-order change often appears unusual, unexpected or uncommon-sensical and there is a paradoxical element to the process of change (Watzlawick et al., 1974). In reference to the first example, a second order change solution
might be to suggest to the misbehaving adolescent that for the
time being he/she seems to need less structure (rules, etc.)
because she/he can't seem to comply with the ones already
established. This attempted solution is qualitatively
different from the first-order solution mentioned earlier.
From a first-order change perspective this attempted solution
seems entirely illogical; how could less punishment ever begin
to solve a problem of continuing misbehavior?

Second-order change solutions focus on the previously
attempted solution. As Watzlawick et al. (1974) points out, it
is the attempted solution which is often at the root of the
problem. In many situations with adolescents, parents and
child care workers attempt to solve a problem by applying more
and more force even when this attempted solution proves to be
unsuccessful. After a while it is this attempted solution, the
application of force, which becomes the problem. Watzlawick et
al. (1974) describe three ways in which problems can be
mishandled:

a) A solution is attempted by denying that a
problem exists. In other words, an action is
necessary but it is not taken.

b) A change is attempted regarding a difficulty
which is really unchangeable or non-existent.
For example, trying to stop somebody from
feeling sad when they have a legitimate reason
to feel that way - action is taken when it
should not be.
c) First-order change solution is repeatedly attempted when a second-order change solution is required. This kind of attempted solution is the same as the one mentioned above where more force is added when an entirely different strategy would be more effective. This kind of error can also take place when a second-order change is attempted when a first-order change would be appropriate. For example when a parent insists that a child "want" to study instead of settling for an increase in the amount of time a child spends studying (Watzlawick, 1974 p. 39).

When problems are mishandled either in the family or treatment home, a long-standing, cyclical pattern can be established that is difficult to alter. Paradoxical interventions are introduced to force the individual or system to adopt a second order solution to the problem.

Weeks and L'Abate (1982) have described three types of paradox: antimony, semantic antimony and the pragmatic paradox. It is this third type, the pragmatic paradox, that is used as a basis for paradoxical psychotherapy. A good example of a pragmatic paradox is the directive "be spontaneous". As you can see this sort of request is impossible to carry out. The Palo Alto group is credited for first using the pragmatic paradox in a research setting and for attempting to uncover a theoretical explanation for it. Their classic paper published in 1956 was entitled "Toward a Theory of Schizophrenia" (Bateson et al., 1956).
The Palo Alto group suggested that schizophrenia could be produced through repeated exposure to a certain kind of, what they called, pathological communication. The term they used for this communication was the double-bind. For double-bind communication to take place, a number of conditions must be met over a period of time. First of all, there must be communication, verbal or nonverbal, between two or more persons who are closely connected (e.g. family members). The second requirement is a recurrent theme of communication between the parties. In other words, a single experience is not considered significant. Thirdly, a primary negative injunction must occur. This refers to a conditional type of communication like "If you don't do so and so, I will punish you" or "If you do so and so, I will punish you". Most often the withdrawal of love or attention is threatened as punishment for some behavior or lack of it. The fourth condition carries the double-bind and consists of a secondary message which conflicts with the first. As Weeks and L'Abate (1982) describe it, this secondary message is generally more difficult to identify because it is usually conveyed at a nonverbal level. The secondary message is inconsistent with the first and puts the receiver of the communication in a no-win situation. A common example of a secondary message is crossing the arms and backing away while a primary message like "I love you" is simultaneously being communicated. The last condition is called a "tertiary
negative injunction" which disallows the victim to comment on the confusing message or to leave the field. The receiver or victim of this kind of pathological communication is left "frozen", not knowing how best to respond to the contradictory messages. Also, as is most often the case, the subtlety of the secondary nonverbal communication leaves the victim unaware of the confusing double-binding situation they find themselves in.

To "release" the victim from his no-win situation the Palo Alto group developed the therapeutic double-bind. In contrast to the pathogenic double-bind which places the person in a no-win situation, the therapeutic double-bind forces the client into a no-lose situation. A commonly used therapeutic double-bind is the "prescription of the symptom". In this case, the client is directed to continue displaying his symptoms and is generally encouraged not to change. This binds the client to accept one of two options, either a) continue the symptom, which implies control over a supposedly uncontrollable behavior, or b) discontinue the symptom, thereby going against the therapist's directive and in the process "curing" himself. Watzlawick et al. (1967) explain the situation, "if he complies, he no longer 'can't help it'; he does 'it' and this, as we have tried to show, makes 'it' impossible, which is the purpose of therapy. If he resists the injunction, he can do so
only by not behaving symptomatically, which is the purpose of therapy" (p. 241).

It appears that part of what makes a pragmatic paradox or therapeutic double-bind work is the message within the message. If a client is told to continue behaving symptomatically the secondary message is "You are in control of your behavior". Once the client implicitly receives the message it makes it difficult to display the problem behavior.

Although the Palo Alto group were the first to research the pragmatic paradox, Alfred Adler is credited with first using and writing about it (Mozdzierz et al., 1976). According to Mozdzierz, Adler used paradoxical techniques to avoid power struggles with his clients. By encouraging the client to display the problem behavior, Adler side-stepped the issue of resistance between client and therapist. Mozdzierz describes some of the paradoxical strategies employed by Adler; 1) Permission - giving the client permission to have the symptom; 2) Prediction - predicting the client's symptoms would return; 3) Proportionality - getting the client to exaggerate symptoms or have the therapist take them more seriously than the client; 4) Pro-social redefinition - reframing or reinterpreting the symptomatic behavior in a positive way; 5) Prescription - directing the client to behave in a symptomatic way; 6)
Practice - asking the client to refine or improve his symptomatic behavior.

Behavior therapists also use a technique which is paradoxical in nature. Implosive therapy uses the process of extinction to eliminate avoidance behavior. Phobic reactions and problems like fear or rejection, sexual deviations, loss of impulse control and aggression have been treated using implosive techniques (Stampfl, 1967). The therapy requires the client to use guided imagery, imagining scenes of some avoided behavior from least anxiety provoking to most anxiety provoking. The client never actually participates in the phobic behavior but instead imagines in detail the most threatening of situations.

Another theorist whose work has a paradoxical element to it is Victor Frankl. Frankl's logo therapy makes use of a powerful technique which he calls paradoxical intention. According to Frankl (1975), he was using this technique in 1925 and documented its use in a paper published in 1939 (as cited in Weeks & L'Abate, 1982). When using this technique, the therapist directs the client to intentionally will the symptom to occur. Frankl encourages the adoption of a humorous attitude towards the symptom and hopes that the client will take a more detached, objective view of their situation.
The goal of paradoxical intention is to interrupt the vicious cycle of anticipatory anxiety which Frankl believes is at the root of anxiety neurosis and phobic reactions. Anxiety occurs when the patient imagines a feared stimulus, thus leading to an avoidance reaction. By intentionally willing the symptom to appear the patient is freed from the cycle of anxiety and avoidance.

Rosen (1953) used a procedure called "re-enacting an aspect of psychosis" to treat psychotic behavior. This procedure, which is similar to prescribing the symptom, involved directing the patient to re-enact any bizarre behavior that they had exhibited. Rosen provides a rationale for the procedure:

Whenever your hunch tells you they are in danger of repeating some such irrationality, you beat them to the draw by demanding that they re-enact just exactly the piece of psychotic behavior that you fear they may fall into again. Perhaps your boldness indicates to the patient that you are willing to take a chance of making him act crazy because you are convinced that he no longer can. Perhaps it has something to do with the patient's sense of shame when you ask him to do something foolish and remind him that he used
to do this foolish thing. Sometimes the patient makes an attempt to re-enact the symptom which comes out very feebly, obviously not spontaneous, and sometimes he will say 'he did it to humor you'. When the patient has clearly lost his touch, the therapist has reason to rejoice. (cited in Weeks & L'Abate, 1982, p. 11)

In his use of paradoxical techniques with psychotic patients, Rosen (1953) claims to have achieved remarkable success. One of his studies reports that 36 out of 37 schizophrenics recovered to the extent of achieving the emotional stability of normal individuals. Rosen's work is highly creative and provides a good example of how paradoxical psychotherapy can be used with even the most severe psychological problems.

Gestalt therapy clearly seems to have a paradoxical element to it. Beisser (1970) suggests that Gestalt therapy is based on a paradoxical theory of change. According to him, "change occurs when one becomes what he is, not when he tries to become what he is not" (p. 77). A technique known as "exaggeration" requires the client to repeat behavior in amplified movements or gestures, with the goal being to uncover the hidden meaning of the behavior. This emphasis on achieving
awareness of where one "is" before being able to move on and change behavior is also similar to client-centered Rogerian therapy. In client-centered therapy, the client is encouraged to accept himself in the present so as to move forward in a process of self-actualization (Rogers, 1961). Both the Gestalt therapist and the client-centered therapist assume the paradoxical role of not being a changer.

Research by the Milan group (Palazzoli et al., 1978) had a direct influence on the adoption of paradoxical techniques at the Vancouver House treatment home. Their work which, in turn, was inspired by Watzlawick (1967) is based on a systemic orientation and focuses on the communication and behavioral transactions that occur within the family unit. According to the Milan group, all groups, including the family, have rules that govern the behavior of the unit. These rules, many of which are hidden or unarticulated, provide limits to what is permitted and not permitted in the relationships amongst the group members. Pathological behavior within the family is also governed by these "meta-rules" and the rules are rigidly enforced to maintain the system's status quo. In their book "Paradox and Counterparadox" (1978), the Milan group states that when they are able to discover and change one fundamental rule, pathological behavior quickly disappears.
In order to fully comprehend the work of the Milan group, one must be able to appreciate the systemic orientation to behavioral change. Many of the theories of human nature, psychoanalysis included, are based on a causal-mechanistic view of phenomena. The causal-mechanistic view suggests that present behavior is determined by previous events in a cause-and-effect manner. Palazzoli et al., (1978) explained the importance of viewing the family systemically:

... we must abandon the causal-mechanistic view of phenomena, which has dominated the sciences until recent times, and adopt a systemic orientation. With this new orientation, the therapist should be able to see the members of the family as elements in a circuit of interaction. None of the members of the family inevitably influences the behavior of the others. This is because every member influences the others, but is in turn influenced by them. The individual acts upon the system, but is at the same time influenced by the communications he receives from it. (p.5)

Within the family unit, with each member influencing and being influenced by the whole, surfaces the identified patient whose behavior threatens the homeostatic tendency of the group.
The identified patient in acting in a bizarre, disruptive or withdrawn manner is reacting, in the best way he knows how, to the conflicting double-binding messages he receives from the rest of the family unit. Paradoxically, the disturbing behavior of the identified patient which has brought the family into therapy, threatens the stability of the unit and at the same time permits the status quo to continue. The family is said to be in "schizophrenic transaction", hanging on desperately to the family rules which prohibit any change in the relationships amongst family members, and producing, in turn, the identified patient who functions to protect the stability and cohesion of the group (Palazzoli et al., 1978).

Recognizing this powerful tendency to protect the status quo, the Milan group devised strategies to counter the family's homeostatic maneuvers. The most significant general strategy is called "positive connotation" (Palazzoli et al., 1978). Facing the problem of attempting to change a system where each of the members covertly resist change and believe that "someone else needs to change", the Milan group decided their most effective strategy would be to positively connote the behavior of each and every member of the family. By doing so they believe they "gain access to the systemic model" (1978, p. 56), and underline and confirm the family's homeostatic tendencies. To provide a rationale for supporting the family members'
behaviors the therapist suggests that each of them is doing their best to provide the family with stability and cohesion.

Positively connoting the symptoms of the identified patient and the behavior of the other family members explicitly suggests that the family should remain the same and implicitly suggests that they should change. For as the Milan group states (1978, p. 61); "... positive connotation implicitly puts the family in a paradox; why does such a good thing as the cohesion of the group require the presence of a 'patient'?

Now that a general review of the strategic/systemic literature has been presented, the focus will be narrowed to examine strategic/systemic methods and ideas as they specifically relate to the residential treatment context. In order to do this, the few studies that have been reported on the use of paradoxical methods in residential setting will be reviewed, followed by a review of the strategic/systemic literature as it specifically relates to significant concepts within the residential treatment context.

The first paper describing the strategic use of paradoxical procedures on an in-patient child unit was written by Jessee and L'Abate (1980). As was mentioned earlier, these authors believe that paradoxical procedures can be very
effective with children because the interventions require limited verbal ability and insight, are normally short-term, can include an interactional perspective, and have proved to work well with oppositional individuals. The authors present us with three case examples and contraindications for this type of intervention are discussed. In the first example provided, an 11 year old boy had been hospitalized for repeatedly stealing toys. The boy's mother reported a long history of depression and said that she handled all matters concerning the boy except for stealing which was dealt with by both the mother and the father. The father, who worked odd hours and had little contact with the boy, would then dole out some discipline. The staff noticed that the boy had difficulty establishing relationships with the male staff in the hospital but got along easily with females. The intervention used was as follows: the staff got together and told the boy that they now understood how difficult it was for him to let them know that he wanted to spend more time with the staff. He was then told that whenever he wanted to spend some enjoyable time with the male staff he was to "take" (his word for stealing) a magazine from the counter. The staff also told the boy that when he "took" the magazine, the staff, male and female, would get together and talk about the situation. The boy was congratulated for creating an opportunity for staff to get together and share some information.
The boy's reaction to the directive was astonishment and confusion, followed by anger and refusal to do the task even though he had previously agreed to it. The authors report that the boy never followed through on the task and never stole again either. In analyzing the intervention, we can see that the symptom, stealing, was positively connoted and given a pro-social rationale - getting the staff together. Also, we can see that the directive prescribes the symptom and provides an explanation for its function which parallels the hypothesized function it has within the family system. The authors report that the following week the father and the boy spent an afternoon together, something they had not done in years. In addition, the mother reported feeling better than she had in weeks and exhibited a much brighter affect. These reports would suggest that the intervention had systemic repercussions, changing established patterns of interactions and upsetting the family homeostasis.

In the second case study, a boy who had a long history of argumentative, oppositional behavior had these presenting problems prescribed. It was hypothesized that the disruptive behavior of the boy functioned to distract the parents from their own difficulties with each other. The boy was told that his arguing with a female nurse was a good thing because it helped her come out of her depression. He was told to
misbehave in front of her whenever he felt she was depressed. The authors report that this prescription was used in the hopes of enabling the boy to get an experiential understanding of the function of his behavior in the family. As with the first example, the boy refused to follow through with the prescription and responded with blatant anger to the directive.

In the third case study, an 11 year old boy was admitted to hospital after the accidental shooting death of his younger brother. Apparently the boy had a long history of dangerous and destructive play and was very accident prone. The authors prescribed that the boy should have two accidents a day, using the rationale that if they are going to happen, then he might as well learn to control them. They report that within three days the boy stopped having any accidents.

Another intervention reported by Jessee and L'Abate (1980) provides the child with an explanation for his behavior and positively connotes it. They report that this procedure can be used in a general way and has been found effective with various behavioral difficulties. For instance, the child who is having difficulty settling at night can be told that his staying up is an indication that he loves his parents very much and his parents would be proud of him for demonstrating his caring so convincingly. He is then encouraged to stay up until he feels
like he has shown enough caring for his parents. The behavior, then, becomes framed in such a way that staying up reassures the child that he is cared for by his parents, labels the distress as a positive expression, and prescribes the symptom in a way that removes the need for it.

It is interesting to note that in the above case examples the symptomatic behavior that was presenting itself within the family environment was also displayed in the hospital setting. Jessee and L'Abate's (1980) interventions seek to capture the interactional dynamics that are occurring in the hospital setting which parallel the dynamics which are happening in the home setting. Although the actors are different from one setting to the other, the intervention is aimed at the same symptomatic behavior. One has to wonder, however, how often the case will be so clear cut with the identified patient displaying the same symptom in the hospital setting as he displays at home with his parents.

Jessee and L'Abate (1980) suggest that paradoxical interventions may be most successful with defiant children, especially those who resist being supported or helped in any way. They also suggest that with highly compliant children, compliance-based paradoxical interventions can be quite effective. With compliance-based paradoxical prescriptions the
assumption is that the symptom will cease when the patient attempts to willfully bring on the symptom. Compliance-based prescriptions seem to be especially effective with somatic complaints, depressions and phobias.

Jessee and L'Abate's (1980) report that paradoxical interventions should not be used when children are in intense crisis, are experiencing disorganized thinking or are retarded. Finally, the interventions should always be framed within the reality of the child, using concepts and language that are comprehensive to him/her.

In "Positive Reframing With Children: Conceptual & Clinical Considerations" (Jessee at al., 1982), the authors present us with the theoretical and pragmatic aspects of positive reframing with hospitalized middle-school aged children. The authors of this article credit Watzlawick et al. (1974) for introducing positive reframing as an active agent of change. According to Watzlawick et al. (1974) reframing alters;

... the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and places it in another frame which fits the 'facts' of the same concrete situation especially well or
Jessee et al. (1982) report that positive reframing, amongst other things, serves to counteract the negative effects of psychiatric labelling. Once the child's behavior has been positively reframed, he/she can no longer be seen in a strictly negative light. A new more positive view of the child behavior can affect the group processes and alter established family behavior pattern as well as boosting the child's self-esteem and encouraging progress in his or her intrapersonal maturational development. As the authors state, positive reframing

... may serve as a positive stimulus to the child's developing ability to consider simultaneously both the desirable and undesirable attributes of a particular type of behavior. (p. 315)

The positive reframing article presents two interesting case examples. In the first case, a 12 year old boy was displaying isolative behavior, and a direct approach encouraging him to interact with peers proved unsuccessful. The authors, realizing that "resistance" required an N of at least two, decided to focus on the positive aspects of the
boy's stubborn isolative behavior. They told the boy that, after thinking about it, they had changed their mind about his behavior and thought it was a good attempt to "get in touch with his sad feelings". They also stated that until he got to know himself well he wouldn't be able to satisfactorily interact with others. The boy was understandably confused initially by the message and within a couple of days, he dramatically changed his behavior. The authors report that he began to spend virtually all of his free time with peers and he felt better about himself and more in control of his behavior. Notice that this positive reframe was on the individual level; it does not mention other members of the boy's family or hospital system.

The second significant case example is a paradoxical intervention that belongs to the third or transactional level. Faced with the ever present problem of intense peer conflict on a hospital unit, the authors came up with a reframe that was directed at the whole group. They relabelled peer conflict as an expression of affection and caring using the rationale that "you don't fight with people that you don't care about" (Jessee & L'Abate, 1980 p. 316). The children adamantly denied the validity of the relabelling but conflict such as scapegoating reportedly dropped off significantly.
In each of the above cases, the reframing created a conflict for the child; behavior that was previously considered undesirable took on a positive meaning and the child was actually encouraged to display it. It may be hypothesized that the purpose or intention the child had for displaying the behavior in the first place, whether conscious or unconscious, is disqualified by the new meaning attributed to it, thus leaving the child in a state of confusion about whether or not to continue the behavior. In many ways, this view of the dilemma facing the individual who has been presented with a paradoxical message reminds one of Festinger's (1957) classic theory of cognitive dissonance. Festinger's theory suggests that dissonance is created whenever one cognitive element (belief about oneself, one's behavior or the environment) conflicts with another cognitive element. The theory suggests that at least one of these cognitive elements must refer to oneself. The assumption being that the individual cannot tolerate the discomfort caused by these two conflicting cognitive elements and so he acts in a manner so as to make the two elements consonant. For the child whose behavior has been positively reframed, he can either a) disregard the new definition and continue displaying the behavior, or b) accept the new definition and alter his behavior so as to be consonant with the new meaning attributed to it.
Jessee and L'Abate (1980) report that their most successful reframes on an in-patient unit addressed the entire problem system. In other words, reframes which were transactional, involving all the members of the system, provided the most impact and dramatically altered the behavior of the group members. These authors caution that positive reframing is unlikely to be effective with children who have not reached the concrete operation stage of cognitive development which emerges at the age of 7 or 8 (Inhelder & Piaget, 1964).

Bergman (1980) describes the use of paradoxical interventions to change the resistant behaviors of community home resistsants who are considered chronically disturbed or retarded. The interventions used were initiated after more traditional behavioral approaches had proved unsuccessful. Bergman assumes that symptoms displayed by residents serve some function for them and are maintained by the emotional system within the community home. He also introduces the concept of "context replication", suggesting that the same symptoms that the resident displays in the community home may have served a similar function when the resident was living in an institution or, prior to that, when the resident was living with his family of origin.
Bergman assumes that residents of the home are not "helpless" with respect to much of the symptomatic behavior they are displaying. He suggests that symptomatic behavior in a residential home is often used in a manipulative way, with the residents receiving some "secondary gain" when displaying it. A good example of this dynamic is provided in a case study of a 30 year old man named Brian (Bergman, 1980, p. 68). Brian had been doted on and infantilized during a 20 year stay at a state school for the retarded. Much of his behavior consisted of subtle and not so subtle invitations to others to take care of him and treat him delicately. After trying more direct behavioral approaches to change his dependent behavior the staff decided to use a paradoxical intervention.

The paradoxical approach consisted of first apologizing to Brian for trying to make him act like an adult when, after all, he "was a 3 year old child trapped in the body of a man" (p.68). For the next three days the staff treated Brian like a 3 year old; putting him to bed at 7 pm, making him take naps in the afternoon, and cutting up his meat and mashing his food. After a while Brian responded angrily to the treatment he was receiving and complained to his friends. Within three days the author reports that Brian "metamorphosized" into full adulthood. He became more assertive, organized, and well-groomed and refrained from looking to others for help and
support. Bergman (1980) states that two months after the intervention was introduced Brian was living in an apartment in the community in a fully grown state.

One additional strategy which the author used in the above case is predicting a relapse. After Brian began to show some significant behavioral changes they told him that they were startled by these changes and didn't expect them to last. This strategy further heightens the challenge to prove the staff wrong with a move away from dependency and a "flight-into-health".

Bergman (1980) offers an interesting explanation for the effectiveness of his paradoxical interventions. He suggests that by prescribing a behavior and reframing the motivation for it, the staff are able to assume a one-up position within the house hierarchy. Children who are acting out and are highly resistant to outside interference functionally take control of the power hierarchy within the therapeutic system. By reframing the resistant behavior and prescribing it, the staff regain control and thus assume their normal status in the hierarchy of adult/child transactions (Madanes, 1980). This explanation focuses on the resistance within the system; if the staff continue to push for change and the child refuses to change, the staff appear powerless. However, if the staff
encourages the resistance and, in a sense, authorizes the troublesome behavior, they disarm the children of their means of control. This explanation would suggest that reframing may be the treatment of choice when a power struggle develops between staff and children.

Williams and Weeks (1984) demonstrate some of the possible uses of paradoxical methods in a school setting with pre-adolescent and adolescent children. The authors suggest that a straightforward approach to therapy be tried first and, if resistance is encountered, a paradoxical intervention may then be appropriate. Symptom prescription and paradoxical prediction are reported as being very useful interventions with an adolescent population. With paradoxical prediction the therapist predicts that the student will likely continue to display the problem behavior for some time to come. The author suggests that this sort of intervention works well with highly resistant and oppositional individuals who will alter their behavior just to prove others wrong.

The four articles reviewed above are the only examples reported to date that examine the use of strategic-systemic methods in a setting other than the clinician's office. The case examples presented reveal the ingenuity and creativity of the authors in adapting strategic/systemic methods to fit a new
therapeutic context. One issue which these studies fail to address is the distinctively different role that relationship plays in conventional child care as compared to the role it plays in the strategic/systemic approach. Before concluding the review section of this thesis, let us examine this important issue further.

As was mentioned earlier, most of the literature representing the established approaches to residential treatment suggest that a nurturing, supportive relationship is a key ingredient of therapeutic success (Bettelheim, 1974; Jones, 1980; Brendtro & Ness, 1983). Brendtro (1969) describes the development of a relationship as the formation of human bonds via trust, empathy and communication skills. He goes on to state that "relationship" within child care is the active agent of change; with the development of bonds to facilitate behavior change. In the great majority of literature on residential treatment there seems to be agreement that the staff-child relationship is the essence of child care (Brendtro & Ness, 1983; Kruger, 1980; Pierce, 1982; Trieschman, 1969; Parry, 1984).

When we look to the literature on strategic/systemic theory we find that "relationship" does not take a central therapeutic role as an agent for change. In fact, the
strategic/systemic literature has very little to say about the relationship between client and therapist. The best description of the systemic position in regards to the relationship issue is put forward by Palazzoli et al. (1980). They suggest that to work systemically the therapist should behave in a manner so as to be perceived as a neutral figure. The therapist should not take sides with any members of the family. According to the Milan group the therapist's personality does not act as an agent for change (Palazzoli et al., 1978a).

Many residential treatment programs actually encourage and foster the dependent behavior of their residents. Maier (1981) states "Group care programs have to be structured in such a way that child care workers have time, know-how, and above all, immediate support for dependency nurturance" (p. 31). This "dependency nurturance" takes the form of encouragement (to try new behaviors), empathy, advice giving and physical comfort. This approach contrasts sharply with the "no-change" position often taken by the strategic therapists. Unlike the position taken by conventional child care workers, who encourage change and accept the role of a facilitator of change, the strategic therapist often takes an equal and opposite position, encouraging the status quo and avoiding credit for any change that may occur (Watzlawick et al., 1974). This major
difference of opinion over the role of relationship as an agent of change will be discussed further in a later section.

As we can see from the above review, little has been written on the use of strategic/systemic methods in the residential setting. Of the few articles that have been reported, there is no mention of how strategic/systemic methods can be incorporated into the general philosophy of residential treatment. The adoption of these new methods into residential treatment inevitably produces some theoretical complications. Following the case study presentation of a selection of interventions used at Vanhouse some of these theoretical complications will be described.
CHAPTER 3 - METHOD OF STUDY

THE CASE STUDY AS A METHOD OF RESEARCH

The case study is a fairly common research strategy in psychology, sociology, political science and planning. The case study approach was specifically chosen for the present research endeavour for its ability to retain the holistic and meaningful characteristics of the real-life events that occurred at the Vanhouse Treatment Home.

The type of questions asked in this thesis determined the selection of the research method. The purpose of this thesis is to describe the use of strategic/systemic methods in a novel setting; the residential treatment home. Previous literature on this topic is relatively non-existent. Therefore, the aim of the present study is to address the "how" questions that pertain to the implementation of a unique treatment approach. These questions, which were stated in the introduction, refer to how the strategic/systemic methods were implemented and how the residential context influenced that implementation.

In addition to "how" questions, this thesis is concerned with "why" questions that contribute to the development of theory. "Why" questions are explanatory in that they attempt
to connect the results to the established theory. As we can see, the questions posed by the thesis, which follow directly from the stated goals, determine its structure and focus. According to Yin (1984), the case study is the research method of choice when a "how" or "why" question is being asked about a contemporary set of events, over which the investigator has little or no control.

Yin, in his book "Case Study Research" (1984), provides an excellent discussion of the case study method and helps to distinguish it from other research strategies. Yin defines the case study as;

...an empirical enquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used. (pg. 23)

Unlike an experimental research strategy, which deliberately divorces a phenomenon from its context, the case study attempts to capture the phenomenon in its natural setting. The experimental situation requires the researcher to isolate a few significant variables and "control" the context in order that quantitative statements may be made concerning
the relationship between those significant variables. The case study, by contrast, takes a more holistic view of the phenomenon and attempts to illuminate the significant variables and make qualitative statements concerning the relationship between them.

Yin (1984) states that traditionally the single- and multiple-case study has been viewed as a less desirable form of enquiry as compared to either experiments or surveys. He cites three common complaints that have been levelled against the case study method. The first complaint focuses on the lack of rigor that has been associated with the case study. Yin acknowledges that many case studies have been guilty of sloppy research methods and that biased views have previously tainted the findings and conclusions. However, he notes that this criticism is not unique to the case study, as bias can also enter into the conduct of experiments and other research strategies.

The second common complaint concerns the scientific generalizability of the case study method. Generalizability refers to the research study's external validity. Typically, critics who question the generalizability of the case study are implicitly contrasting the situation to survey research. If a sample is selected correctly in survey research then it should
readily generalize to a larger universe. Yin (1984) states, however, that this analogy to samples and universes is incorrect when dealing with case studies. He points out that survey research relies on statistical generalizations, whereas case studies (as with experiments) rely on analytical generalizations. With analytical generalizations the researcher's goal is to generalize a particular set of results to some broader theory. Case studies, then, do not represent a "sample", and their results are generalizable to theoretical propositions, not to populations or universes.

Relating the above discussions to the case at hand, namely the Vanhouse treatment approach, the results obtained at Vanhouse are not intended to be used as a representative sample of a larger population of residential treatment approaches. Instead the results are intended for the purpose of expanding and generalizing theories; specifically those which are concerned with residential treatment and the strategic/systemic orientation to behavioral change.

The third frequent complaint that Yin (1984) notes is that case studies take too long and result in massive, unreadable documents. With reference to the present case, where the participant-observation strategy was used to collect data, the time investment was considerable. However, as Yin points out,
a good case study does not require the investigator to spend an inordinate amount of time in the "field" in order to collect sufficient data. As for the "unreadability" of the case study, Yin (1984) suggests that the prospective investigator should read his book to solve this problem.

THE SINGLE-CASE DESIGN

There are both single- and multiple-case designs within the case study method. Yin (1984) states that there are a number of circumstances that dictate the use of the single-case design, including; the critical case, the extreme or unique case, and the revelatory case.

The present study is clearly an example of the revelatory case. The revelatory case study may be described as an observation and analysis of a phenomenon previously inaccessible to scientific observation. An investigation of the Vanhouse treatment method is revelatory in that an approach of this type has never previously been attempted or described. The purpose of the study is to reveal the nature of the phenomenon and to test theoretical propositions that have previously been suggested in the associated literature.
When using the case study method it is important to define the specific unit of analysis. The unit of analysis refers to the parameters of the phenomenon under investigation or the particular focus that the study takes. In the present study the focus is on the use of strategic/systemic methods in a residential setting. The unit of analysis includes the treatment home as the context, but the "case" cannot be defined as the "treatment home" itself. If, for example, the unit of analysis had been the "home" in general, then the descriptions would have focused on all aspects of the behavior that occurred at Vanhouse. However, not all of the behavior that occurred at Vanhouse is of equal importance to the focus of the study. The behavior which is of particular interest concerns the implementation and use of strategic/systemic methods in the residential setting. In order that the strategic/systemic approach is adequately understood certain contextual elements must be described. This explains the description of the previous treatment approach at Vanhouse as well as some of the other descriptions which are less central to the strategic/systemic approach.

As was stated earlier, the present study is a single-case design. Using Yin's (1984) terminology, the study is an "embedded" rather than a "holistic" design. A holistic design would describe and analyze the global nature of the treatment
approach at Vanhouse, while the embedded design focuses on certain aspects, or "subunits", of the approach. These subunits are described separately under headings such as; Relationships, Rules and Consequences, Interventions, etc.

The subunit which receives the most attention is the "Interventions", which includes the description of actual case examples. Although the interventions are presented as "case examples", the design should not be confused with a "multiple-case design". The intervention examples are presented for the purpose of illuminating the larger unit of focus, the strategic/systemic approach, and for extrapolating propositions to broaden the theoretical framework. A multiple-case design, in contrast, would focus almost exclusively on the intervention case examples, with only a brief description of the other aspects of the approach. For the present single-case design the interventions are provided in order to make the study more robust. A detailed description of the strategic/systemic approach in operation helps to distinguish it from other residential approaches and provides data that can be used to formulate some general theoretical propositions.

DATA COLLECTION

According to Yin (1984) case studies may be based on six different sources of data collection; documentation,
interviews, participant-observation, direct observation, archival records, and physical artifacts. The present study makes use of the first three sources of evidence.

The documentation that was analyzed included: the daily log reports for each of the residents, a "message" book which was used to record the strategic/systemic verbal interventions, minutes from weekly staff meetings, progress reports, and history/demographic information that had previously been recorded for each of the residents.

The daily log reports consisted of a written description of the residents' behavior, which was recorded in separate note books for each resident. These logs were used to ensure that the staff were aware of the "events" occurring in the house and to monitor the progress of the resident through the treatment process. As a source of evidence for the case study the logs were analyzed for indications of behavioral change, and to determine how the staff handled specific issues that emerged.

The "message book" was an innovation in the approach that was initiated by the author of the thesis as a participant-observer. The purpose of this book was to record the strategic/systemic verbal interventions and the initial reactions of the residents to these interventions. The case
examples that are provided in the results chapter were selected from the numerous interventions that were recorded in the message book. The message book is described further in the results chapter.

Minutes from the weekly staff meetings provided a good source of evidence of the developing treatment philosophy at Vanhouse. These meetings, which were attended by the author as a staff member, functioned as an arena for open discussion of the strengths and weaknesses of the treatment approach. Adjustments to the approach and the formulation of strategic/systemic interventions also occurred during these meetings. For these reasons, the weekly staff meetings proved to be an invaluable source for gathering case study evidence.

The interviews that were used to gather information were of an open-ended nature. The coordinator of the program and a family worker were interviewed informally regarding their perspectives on the developing approach.

The source of evidence which provided the most information was the ongoing observations that the author had as a participant-observer. The author was employed as a child care worker in the home, two days a week, for approximately six months. Much of the information that was used in the case
study came from observing and participating in the weekly staff meetings. The author also had the opportunity to help formulate and deliver strategic/systemic interventions. The quality and accuracy of the investigation was significantly enhanced as a result of this "insider's" view of the phenomenon under study. Of course, as Yin (1984) reminds us, the participant-observation role may potentially produce certain biases. Due to the fact that the present study is descriptive in nature, as opposed to evaluative, these biases are hopefully kept to a minimum. If, for instance, the study involved making comparisons between two different treatment approaches, then the author's relative "objectivity" would be a more serious concern.

DATA ANALYSIS

According to Yin (1984), when conducting a case study analysis it is important to have a general analytic strategy. The analysis in the present thesis is based on a descriptive framework, which helps to organize the case study. This framework covers the various elements or "subunits" of the case; i.e., "The Residents", "The Staff", "Interventions", etc., and each of these elements is examined in light of the initial questions posed by the thesis.
In addition to the descriptive analytic framework, this thesis also relies on some general theoretical propositions to guide the analysis of the data. These propositions were stated in problem form in the introductory chapter under the following headings; "The Identified Patient Problem", "The Surrogate Parent Problem", "The Problem of Resistance", and "The Problem of Control and Discipline". In the concluding chapter the results obtained from observations of the Vanhouse approach are tested against the theoretical propositions derived from the existing literature. The ultimate goal in the analysis of the data is to accurately describe the phenomenon under study and formulate hypotheses that contribute to the development of theory. The descriptive framework and the structure provided by the initial theoretical propositions helps to focus the analysis and provides organization for the entire case study.

LIMITATIONS

As was stated earlier the present case study relies on analytic generalization as opposed to statistical generalization. In essence this means that the results and conclusions of the study are generalizable to the broader theory of residential treatment and systems theory. If the study were based on statistical generalization then some comparative, quantitative statement could be made about the
relative success of the approach. However, the purpose of the study was not to evaluate the Vanhouse approach, but to understand and identify the significant variables associated with the implementation of a novel treatment approach in the residential context.

In a very real sense, the study represents a "test case" for the theory suggested by the residential treatment and strategic/systemic literature. The Vanhouse staff's interpretation of the strategic/systemic literature represents a potential limitation of the study. If their interpretation and implementation of the theory is an inaccurate representation, then the study fails as a valid "test case" of that theory.

Finally, a note about how the results can be used by other investigators and practitioners. The present study will help to focus future investigations in the residential treatment field and, hopefully, will provide guidelines for the practitioner who wishes to implement a similar approach. In reference to future investigators, a replication of the results will help to determine whether the strategic/systemic theory's propositions are correct, or whether some alternative set of explanations might be more relevant.
The purpose of this chapter is twofold. The first section is concerned with the residential context; highlighting those aspects of the approach which distinguish it as a systemic orientation to residential treatment. The second major section deals with the strategic/systemic interventions themselves and their place within the overall treatment plan.

THE DEVELOPMENT OF A SYSTEMIC APPROACH

As was stated earlier, the Vanhouse treatment approach that existed prior to the introduction of strategic/systemic methods was primarily relationship based with an emphasis placed on providing the residents with clear, consistent expectations for their behavior. An underlying assumption of this previously established approach was that residents would begin to alter their inappropriate behavior as a response to the expectations and discipline applied by the treatment staff. In order to have an impact on the residents' behavior the staff made an effort to develop strong, supportive relationships with the adolescents. The development of these relationships was based on the premise that close, interpersonal relationships are inherently therapeutic.
The previously established approach may be described as linear, or using systems language, one that encourages first-order change solutions (Watzlawick, et al., 1974). First-order change refers to change within a given system; it is a change in quantity, not quality. First-order change involves using the same problem-solving strategies over and over again (Weeks & L'Abate, 1982). Typical disciplinary action is based on a theory of first-order change. For example, some behavior is displayed by an adolescent which is considered inappropriate, and the conventional response by parents or staff is to apply a consequence to act as a deterrent. If the inappropriate behavior occurs again then the same consequence or a more severe consequence, is administered in a step-wise fashion.

The staff at Vanhouse became disillusioned and frustrated with the conventional, first-order, disciplinary responses to the inappropriate behavior of the residents. Although this kind of direct intervention may be relatively successful with adolescents who are still residing with their family of origin, the Vanhouse staff were of the opinion that in a residential setting these interventions were inadequate and in some cases countertherapeutic.

One of the reasons why direct or first-order change solutions were thought to be inadequate may be attributed to
the profound resistance exhibited by the residents. If, for example, an oppositional adolescent repeatedly failed to return on time for curfew then progressively disciplinary consequences would simply heighten the adolescent's rebellious nature and disturb the treatment relationship by creating an intense power struggle. The staff also questioned whether direct, disciplinary measures produced any long-lasting, internalized change in the adolescent's behavior. In order to avoid countertherapeutic power struggles and to act as a catalyst for significant, long-lasting change the staff focused on second-order solutions to the residents' behavioral difficulties.

Second-order change refers to a change in the system itself (Weeks & L'Abate, 1982). In other words, instead of trying to promote change by staying within the system, the system itself is altered. By altering the structure and meaning of the interaction between the members of a system a qualitative shift occurs. In the residential context the "system" includes the relationship between the residents and the staff. When first-order change solutions are attempted in the residential setting the relationship between resident and staff is defined as one where the staff encourages, directs or demands change from the resident. If the resident complies with the staff wishes then there has been a quantitative change in the behavior, i.e. the behavior is displayed less
frequently, however the structure of the interaction between the two parties remains constant. In order for second-order change to occur there must be a change in the structure of the interaction, i.e. a change in the system itself. The change in the Vanhouse system occurred when the staff assumed the paradoxical role of not being a "changer". That is, unlike conventional child care workers, the Vanhouse staff assumed the paradoxical position of encouraging the status quo by positively connoting, predicting or prescribing the problem behavior.

To be specific, a shift in the Vanhouse system's structure occurred when the relationship between staff and resident was qualitatively changed. When the relationship structure within a system changes the meaning attributed to that relationship also changes. As we shall see in the following section, structure and meaning are inextricably tied together.

The following sections describe the attempts made by the Vanhouse staff to alter their approach so that it would be consistent with a systemic orientation to behavioral change. These descriptions are followed by specific examples of the strategic/systemic interventions employed at Vanhouse.
Weeks and L'Abate (1982) discuss the properties of an open system. These properties are defined as wholeness, relationship and equifinality. Wholeness refers to the concept that a system is more than just a collection of parts. It is a set of interdependent parts operating as a unit. The second property of a system, relationship, refers to the concept that the system can only be understood in terms of the relationship existing among its parts. In other words, the parts are defined by each other. For example, the care giver's role only makes sense or acquires meaning within the context of its relationship to the individual being cared for.

The staff at Vanhouse realized the profound importance of how their relationship was defined relative to each of the other members of the system. If, for example, the staff by their actions or behavior cultivated a substitute-parent relationship with the residents then the residents, in turn, would assume a child-parent relationship with the staff. In systems language this concept is called "complementarity" (Watzlawick et al, 1972).

The staff at Vanhouse examined this crucial issue of complementarity and relationship from the larger perspective of
treatment goals. The primary treatment goal for almost all of the Vanhouse residents was to re-establish a functional relationship between the resident and her family. When the staff examined their relationship with the children they concluded that the development of close, interpersonal relationships would likely disrupt or interfere with the reparative process that would eventually occur between adolescent and parent. In other words, the staff were concerned that the development of ties between staff and residents would jeopardize the natural process of separation and attachment that occurs between parent and child.

From a systemic perspective, the dilemma that faced the Vanhouse staff might be described by Watzlawick (1974) as "when the solution becomes the problem". From a conventional standpoint the "attempted therapeutic solution" is to provide the residents with meaningful, caring relationships as an active agent for change; the understanding being that close interpersonal relationships are inherently therapeutic. However the "attempted solution" becomes the "problem" when the development of these relationships serves to jeopardize the "meta-goal" of re-establishing a functional family unit.

In order to avoid being placed in a position that might undermine or block any beneficial interaction between
adolescent and parent, the staff decided to re-define their relationship to the residents. Essentially this re-definition meant that the staff did not become too involved with the personal lives of the residents and steered clear of any "surrogate parent" kinds of behavior. Although the staff were still pleasant and generally accessible to the residents they avoided being put in a position where the residents might become dependent or overly involved with them. In doing so the staff hoped that the adolescents would turn to their families to meet their needs for belongingness and intimacy and not to the staff.

To redefine their relationship to the residents, the staff primarily changed the level of communication in the home. Instead of always empathizing or encouraging the residents to talk about their problems or worries, the staff redirected them to bring up their concerns in a family therapy session or with their parents directly. The staff also refrained from asking the residents personal questions or becoming too involved with their social lives.

It is impossible to report on the consequences of the change in staff/resident relationships with any certainty but some behavioral consequences may be hypothesized. First of all a few of the residents were known to complain that "the staff
didn't really care about them, they were only at the home because they were being paid to be there". A number of the residents were also, on occasion, generally hostile towards the staff without any apparent reason. And finally it was observed that a few of the residents behaved aggressively when staff were asking for minimal compliance with the house expectations.

During a staff retreat that took place approximately seven months from the date when the systemic/strategic approach was instituted, the staff addressed this issue of relationship. The general consensus of the staff was that perhaps their attempt at disengaging from the residents had resulted in this increase in hostility directed at the staff. The initial treatment goal of avoiding interfering with the process of attachment and separation between the adolescents and their parents may have been successful, however, a by-product of the disengaging may have been this observed increase in staff-directed hostility.

To remedy the situation it was decided that staff would present a more engaging presence to the residents. At the same time, the staff were quite determined not to engage the adolescents to the extent that they had with the previous treatment approach. It was decided that the relationship that should exist between the staff and resident would be one where
the staff were generally supportive and interested in the residents while at the same time avoiding taking on, or being put in, the position of surrogate parent.

As the reader might imagine, it is a difficult task, when living day to day with adolescents, to engage them to the extent that the relationship is one of caring and genuine interest without becoming overly involved and encouraging dependent behavior. Of course, the way in which staff members relate to each of the adolescents is dependent on the individual resident's relative engagement or disengagement with the staff. In some cases, with overly involved residents the staff consciously backed-off in order that the adolescent might become motivated to engage with more "significant others" in their lives.

This relationship issue is an important element in a systemic/strategic approach to residential care. It appears that the staff encountered a conflict in treatment goals; on the one hand, systemic theory would seem to suggest that a neutral, disengaged relationship is required so that the adolescents are not "drawn away" from interaction with their families, and on the other hand, from a residential care perspective, a disengaged relationship leads to unresponsive and hostile behavior on the part of the residents. The staff
adopted a compromise between these two positions and began to present a more engaging presence while leaving the residents "room to move" so that they might re-establish functional relationships with their families.

It may be said that the previously established "complementary" relationship between the staff and residents was substituted for a more "symmetrical" one. The complementary relationship was one where the staff's role was defined as nurturing and supportive while the residents assumed the role of those in need of nurturing and support. A more symmetrical relationship between the two parties existed when the staff refrained from always being in the nurturing role, and the residents, in turn, were free to assume a role other than the vulnerable, supported one. In essence, a more symmetrical relationship between the two parties encouraged the residents to draw on their own strengths and the strengths of their families.

Another important relationship that the staff examined from a systemic perspective was the one that existed between the staff and the resident's family. An article by Menses and Durrant (1987) argues that most "traditional" models of residential care ignore the context within which adolescents and their families make sense of placement. They suggest that
the meaning of placement is often one that exacerbates feelings of failure and removes responsibility from the family. To remedy the situation these authors suggest that the residential staff "frame" the placement as a "rite of passage", which marks the change of context to one in which the family is able to stand up to the problem together.

The staff at Vanhouse were also aware of the disempowering aspect of placement and avoided triangulating themselves with family members. What is meant here by "triangulating" is that the staff avoided assuming or being put in the position of taking over the responsibility for "curing" the adolescent in isolation from the family unit. Triangulation refers to the struggle that can develop between the staff, family and adolescent. To avoid this struggle, the staff made sure that whenever communicating with family members they acknowledged and respected the family's integrity and resources. For example, to communicate a simple message of respect, the staff consulted with the residents' parents about an appropriate bedtime for the adolescents. Clothing money supplied by the ministry was also passed on to the parents so that they would assume responsibility for their child's purchases. These and other messages communicated from staff to family members functioned to maintain the family's integrity and encouraged their participation in the solution to the family problem.
Another relationship which required examination when providing treatment from a systemic perspective was the relationship of the staff to the larger system which included the community resources and ministry personnel. Treatment goals and interventions within the home may contradict with those planned by workers in the field. The staff at Vanhouse closely monitored both the response to their interventions by the outside system and the independent actions taken by workers in the field that might affect the residents. When working from a systemic perspective, the staff must be aware of, and not underestimate, the potential impact of all the members of the resident's system; family, peers, staff and community resources.

RESISTANCE

As "reluctant clients", adolescents provide an immense challenge to those in the position of administering treatment. For the adolescent, change or compliance with treatment expectations may be interpreted as disloyalty to her family. The resident, by altering her inappropriate behavior, may feel that she is implicitly suggesting that the staff are more successful at "parenting" her than her own parents were. In addition, the resident likely feels obligated to protect the family's status quo by continuing to play her part in the
family "drama" (Hoffman, 1981). One way of dealing with this extreme resistance is described later in the section on interventions. In addition to the specific interventions described later, the staff adopted a position in relationship to the residents which helped to minimize the resistance factor. In practice, this meant that the staff refrained from "overpowering" or directing the residents to behave in a certain way. When intervening with a resident's behavior the staff made it clear to the adolescent that she was really the only one who could decide what was best for her. In this way the staff did not remove the responsibility for behavior from the adolescent.

Another type of resistance encountered at Vanhouse was provided by the adolescent's peer culture. The Guided Group Interaction approach described earlier focuses on the powerful influence of this peer culture and attempts to utilize this force to alter the behavior of the residents. At Vanhouse, the staff were aware of how difficult treatment could become when the residents "banded together" and viewed the home as an "us" (residents) versus "them" (staff) situation.

It may be hypothesized that adolescents in care tend to perceive the staff as the "enemy" because it helps to develop a cohesive, group feeling amongst the residents. To minimize the
detrimental effects of this staff vs. residents phenomenon, the staff at Vanhouse were careful to positively connote the process of developing group "togetherness" and, at the same time, avoided encouraging any perception that the staff were in an adversarial role to the residents. One example of how they avoided this perception has to do with consequences for inappropriate behavior. In residential settings when a privilege such as the use of the stereo is being abused by a number of residents, a typical consequence might be to withdraw the use of that privilege for the entire house. The outcome of this intervention might be 1) the residents use their peer influence to discourage any further misuse of the stereo, or 2) the residents band together and direct their hostility at the staff by further misuse and disregard of house expectations. The staff at Vanhouse were careful not to use this kind of intervention when they suspected the residents might respond in this latter manner. It was important that staff were aware of and knowledgeable of group dynamics in order to adequately assess what type of intervention would be most appropriate.

From a general standpoint, resistance in the home was dealt with by essentially trying to sidestep the issue altogether. As was reported earlier, Jessee et al. (1982) point out that "resistance requires an N of at least two". By not showing up for the "battle of wills" the staff were able to
minimize the "us and them" phenomenon typical of residential care.

RULES AND CONSEQUENCES

In order to avoid institutionalizing the house, the staff were concerned about keeping the rules simple and practical. To avoid any power struggles associated with house rules, the staff presented them in a matter-of-fact manner and explained the necessity for having rules in a residential setting. The residents were given the opportunity to discuss and question the rules at group meetings, and on occasion, rules were changed if the need arose.

The consequences applied for a failure to meet house expectations were as closely linked to the inappropriate behavior as possible. For example the consequence for abusing house privileges such as T.V., stereo, cooking facilities, etc. was a temporary removal of that privilege. If a resident stayed out past curfew, they were expected to return that much earlier the next night. When a resident was away from the house overnight, they were expected to stay in the house the next night.
A general rule of thumb at Vanhouse was to avoid overusing a form of discipline. In other words, if a resident failed to return home for a few days, then the staff would not apply a strict consequence such as grounding for three days. If a resident continued to break an established rule, the staff investigated the possibility of using a novel intervention rather than progressively increasing the consequences to match the infraction.

This approach to discipline was in accordance with the theoretical position on problem formation and resolution proposed by Watzlawick et al. (1974). By refraining from mechanically applying an apparently unsuccessful sanction, the staff avoided the situation where the "attempted solution becomes the problem". If the staff were to progressively remove all of the residents' privileges as a means of controlling inappropriate behavior, then this "attempted solution" might very well lead to a larger problem such as repetitive AWOL'ing or incorrigible damage to the therapeutic relationship between staff and resident.

Whenever a situation arose where the "direct" approach to problem resolution appeared inadequate, that is, when the application of a standard consequence did not alter the problematic behavior, then the staff would use an "indirect"
An indirect method was one that utilized a second-order change solution or, what may be called, a strategic/systemic intervention. These interventions were used in Vanhouse both to deal with management kinds of problems and general treatment issues. Of course in a residential setting, management and general treatment issues or goals may overlap considerably.

The strategic/systemic interventions are discussed in the next section. Before moving on, let us examine the Vanhouse approach for resolving inter-group conflict. Frequently, in residential settings, there is a lot of infighting amongst the residents about things like stealing, the use of the phone and the establishment of a "pecking order". Redl (1952) chooses to deal with this kind of conflict by ignoring it. He calls this non-intervention "planned ignoring" (1952, pg. 158). The rationale for this decision is that ignoring the conflict and not interfering leads to a resolution of the conflict by the residents themselves. Watzlawick et al. (1974) point out that problems can be mishandled when a change is attempted regarding a difficulty which is really unchangeable or non-existent. Inter-group conflict amongst residents in a treatment home is inevitable. If staff were to regularly interfere with the day to day conflicts between residents, their interference would likely "become the problem".
The staff at Vanhouse also adopted a non-interference strategy to deal with most of the day-to-day conflict between the residents. By not interfering, they allowed the residents the "space" required to work out their own interpersonal conflicts and they avoided faulty interference that could become part of the problem. Of course in certain circumstances, such as when safety was involved, the staff found it necessary to intervene and set limits on the residents' inter-group conflict.

THE PHYSICAL SETTING

The present coordinator of the program at Vanhouse took over the contract to run the house in March of 1980. This contract was negotiated and renewed yearly with the Ministry of Social Services and Housing (MSSH). Included in the contract was the house itself, which is owned and maintained by the British Columbia Building Corporation (BCBC).

The house is situated in a residential area and there is nothing about its outward appearance that might identify it as a treatment home. The coordinator of the home has put in considerable effort over the years to furnish the house comfortably on a limited budget. The staff attitude towards the furnishings was one of respect, and damaged furniture was
attended to immediately. By displaying a respectful attitude towards the surroundings, the staff were indirectly expressing their respect for the residents. It is also thought that respect for surroundings was an important attitude for the adolescents to adopt before moving on to independent living.

Residents were given free access to all areas of the house except for the staff office. Smoking was only permitted in the dining room. The smoking rule was established both for safety and to provide the girls with an area to socialize with each other and with the staff. The designated smoking area created a center for activity and interaction and provided easy access to the adolescents when an intervention was planned.

In summary, then, the physical setting was not underestimated as an important part of the therapeutic environment. By modeling and encouraging respect for the physical surroundings, the staff helped to establish a positive attitude towards the home and the residents themselves.

THE STAFF

As was stated in the introduction there were eleven full time employees at Vanhouse. Six full time child care workers (usually three men and three women), two overnight workers, two
family workers and a coordinator. There were also two people employed as relief staff.

The child care workers at the home had between five and ten years experience within the field of residential treatment. Most of the staff had undergraduate university degrees and one of the family workers had previous social work experience. The strategic/systemic influence can be largely attributed to a family worker who spent some time studying with the Milan Group in Italy.

When the strategic/systemic ideas were first being developed and introduced in April '86 the child care staff were by and large unfamiliar with the strategic/systemic literature. The staff reported that at this time some of them were wary about having to adopt an approach that they had no experience with. After investigating and discussing the potential for using systemic methods in their treatment approach, the staff were generally supportive and excited about the new changes to the program. In the next chapter the importance of staff attitudes towards the approach will be discussed further.

Staffing at Vanhouse followed a shift work schedule with the child care workers working from either 7:00 a.m. to 3:00 p.m. or 3:00 p.m. to 11:00 p.m. The 11:00 p.m. to 7:00 a.m.
shift was covered by an overnight worker who was not responsible for any of the child care worker duties.

During the weekdays, one of the child care workers and either the supervisor or family worker were present at the house from 7:00 a.m. to 3:00 p.m. In the evenings, and on weekend days, two child care workers assumed responsibility for the house. Child care worker responsibilities included the following: keeping daily logs on the behavior of each of the residents, writing synoptic reports at regular intervals during the resident's stay and at discharge, monitoring the behavior of the residents and intervening at appropriate times, ensuring the upkeep of the house including shopping and preparation of meals, initiation and participation in weekly resident group meetings, participating in weekly staff meetings, and formulating and delivering treatment interventions.

The two family workers had different responsibilities in their work at Vanhouse. One of the family workers was mainly involved in doing family therapy with the residents of the home and some Outreach clients. The other family worker also did family therapy with the residents and Outreach clients and, in addition, was responsible for helping to administer and coordinate the home. However both family workers participated in treatment decisions concerning the residents and both
attended the weekly staff meetings. The coordinator of the home was responsible for, among other things, the financial administration of the home, taking referrals and acting as a liaison person with community resources and ministry personnel, and participating in the weekly staff meetings.

THE RESIDENTS

The following information is provided so that the reader may have an understanding of the background or histories of the clients being treated at Vanhouse. During the eight month period in which the author was employed at Vanhouse, from October 1986 to May 1987, there were a total of twelve residents placed at the home. No more than six girls resided at the home at any one time and over the eight month period the average was approximately four girls at a time.

The age of the girls ranged between 12 and 18, with the average being close to 15 years. It is safe to say that all of the girls were having serious difficulties in their family relationships prior to being placed in care. For eight of the twelve girls, family conflict was reported as the most serious presenting problem. Other presenting problems reported at the time of referral included: three of the girls recently had attempted suicide, three had come from families where
neglectful situations had occurred (usually as a result of the parents abusing alcohol or drugs), two of the girls were considered to have drug or alcohol problems themselves, and one of the girls had a history of difficulties with the law.

Background information on the residents revealed that five of the twelve adolescents were members of single parent families at the time they were placed in care. Seven of the residents had come from two parent families, with only one of these being a blended family. Of the twelve residents only one had been adopted.

Before being referred on to Vanhouse six of the girls had spent a brief amount of time in an emergency or assessment resource. Two of the girls had been placed in foster homes prior to their arrival at Vanhouse. Three of the girls had spent some time in another treatment center prior to coming to Vanhouse and one had been in two foster homes and a treatment center.

Upon arriving at Vanhouse and throughout their stay there, most of the girls attended school sporadically. A few of them did not attend school at all and as a result were expected to look for work. One of the girls was known to be working as a prostitute in the Vancouver area.
Seven of the twelve girls returned to their families upon discharge from Vanhouse. Three moved on to other resources within the community and two were discharged to independent living.

One of the most common behavior problems exhibited by the girls during their stay at Vanhouse was AWOL'ing or staying away from the house without permission. Many of the girls were socially involved with friends and acquaintances who spent much of their time living on the streets. Since most of the girls were quite alienated from their families, they seemed to get their need for belongingness met on the streets where a closely knit, supportive group was easily accessible.

For a number of reasons, AWOL'ing presented the staff with an especially difficult problem. First of all, the interventions used to alter this behavior proved to be by and large unsuccessful. Secondly it was found that AWOL'ing residents were very difficult to engage in any sort of significant treatment process. And finally it was observed that AWOL'ing was infectious; once one resident AWOL'd other residents were likely to follow. The staff were of the opinion that if the residents stayed at the home long enough for a group cohesiveness to develop then AWOL'ing was less frequent. If, on the other hand, the residents frequently AWOL'd then
there were fewer of them present in the house at any one time and a group cohesiveness was unlikely to develop. Without group cohesion the residents turned to the streets to meet their need for belongingness.

INTERVENTIONS

Interventions, in a residential context, specifically refer to those actions taken on the part of the staff that were designed to contribute to therapeutic change. This broad definition included the day-to-day interaction between staff and residents and the formal treatment messages that were formulated in weekly staff meetings. The focus of this thesis is on the formal strategic/systemic interventions used at Vanhouse.

As was stated earlier, a major influence on the development of the systemic approach at Vanhouse came from the work of the Milan Group and the theoretical formulations provided by Watzlawick and his associates at MRI. These researcher/therapist groups both rely heavily on the use of language as a means of promoting therapeutic change. The Milan Group presents the family with a formal message at the end of the session in an attempt to "capture" the family dilemma and reframe it in a positive light (Palazzoli et al. 1978a). The
MRI Group use a number of strategic messages, such as prescribing the symptom, predicting a relapse or declaring impotence, to alter the meaning of the symptoms or to redefine their therapeutic position in relation to the client. The Vanhouse approach also utilized formal messages to reframe residents' behaviour and redefine the relationship between staff and residents.

One of the most commonly used paradoxical interventions at Vanhouse was reframing in the form of positive connotations. According to Watzlawick, reframing "...means to change the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the 'facts' of the same concrete situation equally well or even better and thereby changes its entire meaning" (1974, pg. 95). Reframing with positive connotation involved examining a resident's behavior and "picking out" those aspects of the behavior that likely served a positive function for the resident. In most cases it was not very difficult to find something about the behavior which could be put in a positive light.

Palazzoli (1978a) states that the primary function of positive connotation is to gain access to the systemic model. In other words, the Milan Group use positive connotation as a
means of joining with the family so that they may then introduce some systemic change. Positive connotation in the residential setting also acted as a means for joining with the residents and avoided the assumption of an adversarial position in relation to their behavioral difficulties. Presumably when the resident was given the message that others understood and accepted the positive elements of their inappropriate behavior they were then "freed up" to re-examine their behavior and alter it accordingly.

It would appear that many adolescents display inappropriate behavior simply as a rebellious or oppositional response to adult authority figures. By positively connoting, predicting or prescribing the problem behavior the staff removed themselves as targets for the rebellious behavior. Those adolescents who were especially reactive and oppositional with authority figures were found to be good candidates for paradoxical predictions. In one case with a resident who had an especially poor record for school attendance, the staff predicted that she wouldn't be able to attend for more than a few days. This prediction was set up in the following manner: two of the staff let themselves be overheard having a discussion concerning a bet that had been made over the girl's school attendance. The resident in question asked the staff what they were betting about and they told her that one of them
thought she would be able to attend school all year while the other was sure she would drop out within a week. They told her that they had made a bet between themselves about who would be right. The resident was very surprised that they were betting about her and declared immediately that she would not quit school. Over the next few months her attendance record improved considerably.

The above intervention was an attempt by the staff to use the oppositionality of the resident in a positive way. When the resident overheard that a staff member was of the opinion that she would be unable to attend school consistently, she was presumably motivated to prove the staff wrong. From a theoretical standpoint it is not entirely clear why this sort of indirect method is more effective than simply presenting the resident directly with concerns about her school attendance. Perhaps, because the adolescent may have felt she was not improving her school performance for anyone in particular, she was motivated to change her behavior. This intervention acted as a challenge to an adolescent who thrived on proving others wrong, especially when it came to what she could or couldn't do.

This kind of intervention was also used in a more subtle fashion in what may be called a "split team" message. With a
"split team" message the resident is told that some of the staff have a particular opinion concerning the resident's behavior while other staff have a different opinion. For instance, a resident may be told that some of the staff feel she is really not ready to settle down and won't be able to meet the house expectations, while the remaining staff feel that she has had enough of street life and is ready to settle down a bit. The message hopefully mirrors the dilemma faced by the resident herself and helps her to make a choice between the two options. Notice how the first option, "street life", is framed as a place where people go when they are "not ready to settle down". By framing it this way it implicitly suggests that sooner or later she will be ready to settle down.

FORMULATING INTERVENTIONS

A four hour staff meeting was held once a week at Vanhouse. During these meetings, which were attended by all staff members and occasionally some other community workers, the agenda would first cover house business and then each of the residents was discussed individually. Unlike the "problems" typically handled by family or individual therapists, which are identified by the client or clients, the problems to be addressed in the treatment home are identified by the staff. Those problems which were most pressing were
addressed first and more minor issues were tabled for the next meeting.

Some of the typical problems or symptoms that were dealt with at Vanhouse include: drug or alcohol problems, AWOL'ing, general oppositional or obnoxious behavior, anxiety and outbursts of anger. The standard procedure during the meetings was to discuss each of the adolescents and, as a group, decide whether an intervention would be beneficial. If the staff felt that the problem was a serious one and the adolescent was "ready" to receive a message, then the staff, as a group, would work on the wording of the message.

A typical example might be the use of a standard positive connotation message that was used in more than one case. If a girl had recently moved into the group home and was displaying argumentative, oppositional behavior, then the message might go as follows:

"We can see by your arguing and anger at us that you are really quite loyal to your parents. We just want to say that we agree that no one could ever replace your parents".

This message positively connotes the "problem" behavior by associating it with an admirable, pro-social intention; that of loyalty. By framing the behavior positively and acknowledging
the bond between parent and child, the resident will hopefully feel less compelled to resist and reject any interaction with staff. In the words of the Milan group (1978a), an intervention such as this allows the staff access to the systemic model. Theoretically once the resident feels secure that the relationship between her parents and herself will not be undermined or substituted, she will feel less threatened as a relationship develops between herself and the staff.

The staff would work on the above message during a meeting and each word would be chosen carefully to "fit" the individual to whom the message would be delivered. Some of the considerations taken into account when formulating interventions were: 1) does the "language" of the message match the adolescent to whom it will be delivered? 2) Could the message be interpreted in a way so as to make it ineffective or countertherapeutic? 3) Is the behavior in question one that was also displayed at home, and if so, can we formulate the message in a way so as to "capture" the home behavior? 4) Who should deliver the message to get the most impact from it?

When a "problem" was identified the staff would make a conscious attempt to view it from a systemic perspective. To view a presenting problem from a systemic perspective one must take into account the following: 1) What purpose or function
might the symptom have for the adolescent? 2) Who else may be contributing to the maintenance of the problem? This question focuses on other individuals in the adolescent's system, i.e. family members, peers, or staff, that are part of the problem. 3) What solutions have been attempted to resolve the problem thus far? It is essential when examining a problem from a systemic perspective to investigate how previously attempted solutions may be contributing to the maintenance of the problem behavior.

Once the problem had been clearly identified, and the staff had worked out the precise wording of a message, the message (intervention) was recorded in a "Message Book". This book included the date the message was formulated, the purpose of the intervention and the initial reaction (if any) that the resident had to the intervention. Finally, during the meeting a decision was made about which staff would have the opportunity to deliver the intervention. In some cases, to get the most impact from a message, a specific staff member was chosen to deliver the message.

DELIVERING INTERVENTIONS

Once an intervention had been formulated and recorded in the "Message Book" then the staff were ready to "deliver the
message". The specific manner in which the message was delivered was an important part of the therapeutic process. The impact of the message may be influenced by a number of factors such as: 1) Who delivers the message? 2) When is it delivered? 3) How is it delivered? (i.e. formally or non-formally) 4) Is the message delivered privately or are others present?

The staff were of the opinion that in certain cases the impact of a therapeutic message could be increased when a specific staff member delivered it. The relationship between the resident and the staff, as well as the gender of the staff, are two examples of factors that seemed to influence the relative impact of the message being delivered.

Timing also appeared to be an important factor when delivering messages. It was thought that if a resident had recently experienced a significant event with her family, then a message would have more impact if it were delivered soon after the event. Messages were also delivered at the precise moment when the resident displayed the inappropriate behavior which had become a concern. Closely linking the message and the behavior seemed to elicit a strong initial reaction from the resident.
In certain cases the interventions were delivered in-passing, nonchalantly, while at other times the staff assumed a formal, more serious manner. To present the message in a serious manner the adolescent was usually asked to meet with the staff privately for a few minutes.

Unlike the messages delivered by Palazzoli and her associates, who tell their clients that they have a message for them and often deliver it in written form, the messages at Vanhouse were usually presented in a less formal manner. On occasion, the staff member who was chosen to deliver the message would tell the resident that the staff had been discussing her situation and had come up with a certain message. More often the message was delivered in a fashion so as to make it appear spontaneous.

The last factor to mention which seemed to influence the relative impact of a message was whether or not the message was delivered privately. In certain circumstances, like when the presenting problem involved the resident's peers, the staff would deliver the message with significant others present. If the message reframed a resident's behavior then her peers were also introduced to this new outlook on the problem behavior and, presumably, their behavior would alter accordingly.
CASE EXAMPLES

In this section a number of actual interventions used at Vanhouse will be described and analyzed. These specific examples were chosen to show the range of interventions used at Vanhouse. Since there was no control group the relative success or failure of these interventions was difficult to measure. However, from a theoretical perspective and from the author's clinical judgement and observations, tentative conclusions can be made concerning the strengths and weaknesses of each of the interventions. The personal information given below is fictitious.

Case Example #1 - Caren

History and Presenting Problem

Caren, age 16, was placed at Vanhouse after a brief stay at an assessment home. According to her parents Caren was highly disruptive at home and recently was attending school sporadically. Caren had one sibling, an older sister, who from all reports was well behaved and "problem-free".

When Caren's parents met with the staff at Vanhouse they told us that Caren would likely have a "honeymoon period" of
about three weeks, after which she would begin to act up. A report from her previous placement also suggested that Caren was displaying "honeymoon" behavior there and would eventually become disruptive. Prior to formulating the following intervention, Caren's behavior could be described as pleasant, cooperative and a little shy.

**Intervention**

Upon discussing Caren's situation in the weekly meeting the staff felt that she was set up by the parents and the previous placement to begin acting out. Both her parents and the previous placement had suggested to the Vanhouse staff and to Caren that her positive behavior was only temporary and she should therefore get no credit for it. If Caren were to begin acting out then everyone's predictions would come true and Caren's label as a disruptive teenage would be verified. The Vanhouse staff were concerned about the self-fulfilling prophecy of this "honeymoon" prediction and decided to intervene with a strategic message. The message was delivered as follows:

1) "We understand that you have a reputation of having a honeymoon period of three weeks.  
2) We feel that it's better to get these things over with quickly,  
3) so whenever you're ready it might be a good thing to get over the honeymoon."
Caren's initial reaction to the message was, "No! I'm not going to do that here, I like it here".

Analysis

1'This part of the message establishes that the staff are aware of the honeymoon prediction and realize that others have pinned this label on her. 2'The second part of the message suggests that the positive behavior being displayed is time limited and, 3'the last part prescribes the problem behavior and implicitly suggests that Caren is in control of her behavior.

Discussion

By framing the positive behavior as temporary and prescribing the problem behavior the staff placed themselves in the paradoxical position of encouraging the resident to display the symptomatic behavior. The resistance to change that would be expected form an oppositional teenager was countered with a request for the status quo by encouraging the presenting problem. Caren is presented with two options: 1) she can begin to display the symptomatic behavior; thereby complying with the staff's requests and fulfilling the "honeymoon" prediction, or 2) she can continue displaying
appropriate behavior and disprove her parents' prediction as well as refusing to comply with staff requests. From her initial reaction it would appear that Caren chose the second option.

We can see from this example how the oppositionality of the resident is utilized for therapeutic purposes. How can the resident oppose the staff when the staff make a request for a display of the problem behavior? Only by behaving appropriately, which has its own inherent rewards, can the resident prove the staff wrong. On another level the message gives responsibility for control of the behavior to the resident. The implicit suggestion that the problem behavior can be turned on or off gives the behavior new meaning and suggests that it is purposeful.

This kind of message, prescribing the symptom, seems to be most effective with oppositional residents. The fact that the staff makes a request for a display of the problem behavior plays into the rebellious nature of the developing teenager and, in effect, removes the wind from her sails. Another implicit message within the intervention is that the staff are not "afraid" of the symptom and accept the resident's "need" to express it.
Throughout Caren's stay at Vanhouse her behavior remained within acceptable limits. Once she became familiar with the staff and house routines she displayed more disruptive behavior than she had initially. However her behavior was never in the extreme and she usually responded well to the house expectations. Of course it is impossible to determine to what extent the message may have affected Caren's behavior while at Vanhouse.

One final observation about this case is how the message reflects the role that Caren likely plays in her family. Her parents seemed to give credit for all the positive behavior to their other daughter, and put Caren in the black sheep role. The message challenges Caren to take on a new role and disprove her black sheep status.

Case Example #2 - Sandra

Sandra was 16 when she first came to live at Vanhouse. Prior to placement she had been hospitalized in an adolescent psychiatric unit and had been diagnosed as clinically depressed. She had a history of suicidal ideation and had attempted suicide before being admitted to the hospital.
Sandra was one of three children of divorced parents and had lived with her mother and mother's boyfriend prior to coming into care. She had a twin brother who still lived with her father in eastern Canada and an older brother who also lived with her mother.

The presenting problem at time of referral was conflict at home with her mother and mother's boyfriend. She was also described as depressed, suicidal and alcoholic. In her first couple of weeks at Vanhouse, Sandra appeared quite lethargic and spent a considerable amount of time crying and looking sad. Most of her time was spent in her room and she avoided socializing with both staff and peers.

**Intervention #1**

The most serious concern that the Vanhouse staff had when discussing Sandra's situation was the potentially detrimental effects of the psychiatric label of depression. The staff had observed that much of her so-called "depressed" behavior was presented in a dramatic manner. Her parents' previously attempted solutions to the problem were to empathize with her and encourage her to feel less depressed. Sandra apparently accepted the label of depression and was eager to explain to others how "sick" she was. She had been prescribed anti-
depressants and during her first few weeks in the house she took them regularly.

The first therapeutic goal addressed by the Vanhouse staff involved reframing the so-called "depression" as sadness. Whenever the opportunity arose the staff would describe Sandra's behavior as sadness instead of depression. She was never discouraged from displaying her "sadness" and the staff did not engage her empathically when she behaved in this manner. Three messages were used to reframe and prescribe the problem behavior. The first message was delivered while she was crying in her room and went as follows:

1) "When you are tired of crying you will stop, 2) but some people can cry for years."

Sandra's response was, "It's exhausting crying!" and she immediately stopped and had a nap. After sleeping she joined the rest of the residents for dinner and displayed a positive affect.

Analysis

1) The first part of the message suggests that her crying is under her control and predicts that the crying is time limited. There is also the implicit message that if the crying is under her control then it must serve some function. 2) The
second part of the message places the staff in a neutral position in relation to the symptom by suggesting that she may continue crying indefinitely. Essentially this part of the message gives Sandra permission to continue crying.

Discussion

If one hypothesizes that the "purpose" of the symptom is to communicate to others a need for nurturance, then accepting the crying and avoiding the "saviour" role likely confuses the "patient" and makes them re-evaluate their behavior. The crying and the display of a sad affect become socially ineffectual when others fail to respond in a supportive manner. This first message places the responsibility for control over the "depressed" behavior squarely on Sandra's shoulders.

The response to this first message was immediate; Sandra acknowledged that crying was tiring and decided to have a nap and join the group. If, on the other hand, the staff had empathized and nurtured Sandra the result may be an encouragement of the depressive behavior by rewarding its expression.
Intervention #2

The second message was also delivered to Sandra while she was crying. The message was as follows:

"Do you find it more or less helpful for your sadness to cry?"

Sandra appeared confused when the message was delivered and failed to respond to the question.

Analysis

Again, this question helps to frame the problematic behavior as purposeful and under Sandra's control. The message suggests that there may be other ways to deal with her sadness and that perhaps crying may not be helpful. Since the question is an open one, the staff is able to remain neutral in relation to the symptom. The confusion that Sandra exhibited when hearing the message may be a sign that the message was effective. As other clinicians have reported (Weeks and L'Abate, 1982; Watzlawick et al. 1974), a confused response may be evidence that the client is beginning to view the symptoms from a new perspective.
Intervention #3

The third message was delivered as follows:

"It's really helpful for you to get in touch with your sadness. By crying and spending time in your room you are able to get in touch with your feelings."

Analysis

This message is a good example of positively connoting the symptom to reframe its meaning. The crying is framed as a healthy response in the context of growth and rehabilitation. In this example the staff move from a neutral position to actually encouraging the presenting problem.

The presenting problems which have become a concern, crying and isolating in her room, are specifically mentioned in this message. Sandra, indeed, began to spend a lot less time in her room and her crying episodes decreased considerably after these messages were delivered. When talking to her approximately a year after these messages were delivered, Sandra stated that after coming to Vanhouse she began to feel much more in control of her own behavior. She stated, "I realized that I was the best person to help me".
Discussion

These three messages were used in succession to consolidate a different perspective of the symptomatic behavior. The therapeutic goal was to reframe the "sick" behavior as a healthy response to legitimately difficult life circumstances. In Sandra's case the depressive behavior may have served the function of drawing attention to her need for support and guidance. However her excessive crying and isolation had become more of a problem than a solution. By refraining from empathizing with her depressive behavior and giving her "permission" to display it, Sandra was likely freed up to try some new behavior as a solution to her problems.

This case represents one of the most clearly successful interventions used at Vanhouse. Sandra's behavior changed dramatically within a short time period and her affect remained relatively positive throughout her stay at the house. One factor that may have contributed to the success of this intervention is that Sandra was an introspective and curious adolescent. She was interested in what the staff had to say to her and listened to the delivered messages attentively and thoughtfully.
Case Example #3 - Lisa

History and Presenting Problem

Lisa was only 12 years old when she came to live at the treatment home. Prior to placement she had been living with her mother whose own behavior may be described as erratic and unreliable. Her father was living in the U.S. with Lisa's older sister, where he had recently remarried. Although family therapy sessions were scheduled a number of times the parents failed to attend them. Lisa's father was strict with her, stating he would have little to do with her until she "got better".

Lisa was a very difficult person to engage. She ran away from the home regularly and would behave quite aggressively with staff for no apparent reason. She seemed to have very little trust for adults and was easily influenced by her peers.

Intervention

The staff were of the opinion that Lisa's unpredictable acting out behavior was likely being fuelled by the confusing messages she was getting from her parents. From Lisa's point of view, it was unclear whether she would ever be returning to
live with one of her parents. The more vague her parents were about Lisa's future the more desperate and disorganized her behavior became. The staff formulated and delivered the following message:

1) "We understand from your behavior lately that you are feeling very confused about your family. 2) In our experience confusion usually leads to growth. 3) So we expect in the near future you will start to feel less confused."

Lisa's response was, "I'm going to stop doing drugs because they screw up my life and I'm going to start school again on Monday and rest up and eat right".

**Analysis**

1) This part of the message made an association between her behavior and the hypothesized confusion. The purpose here was to legitimize the disturbed behavior and attribute it to some concrete precipitating factor. 2) The second part positively connoted the confusion by suggesting that something good would come from it. 3) The last sentence in the message suggested that the confusion was temporary and that she could expect some change in the near future.
Discussion

The basic goal of this intervention was to help Lisa make some sense of the chaotic situation she was experiencing. The message was essentially an empathic intervention that acknowledged the confusion and anxiety present in her family situation. The staff were hoping that if Lisa could attribute her erratic, irresponsible behavior to a legitimate precipitating factor then she might feel a little less out of control.

From Lisa's initial response one might assume that the message was perfectly targeted and made a significant impact. However Lisa's behavior continued to be inappropriate and throughout her stay at Vanhouse her behavior showed little improvement. One possible explanation for the failure of this intervention may be due to the vagueness of the message. The message did not mention any specific behaviors but instead referred to the resident's general confusion. In addition the second sentence in the message states, "In our experience confusion usually leads to growth". A concept such as this may be too sophisticated to make an impact on a 12 year old. To increase the impact of this type of a message it might be helpful to simplify it and specifically mention those behaviors which are targeted for change.
Weeks and L'Abate (1982) have observed that the most effective paradoxical interventions are often met by the client with a look of confusion or anger. Lisa's compliant response may be evidence that the message was not "powerful" enough to alter her perception of the situation she was experiencing.

Case Example #4 - Shannon

History and Presenting Problem

Shannon, at 18 years of age, was the eldest girl in the home and had a great amount of influence on her peers' behavior. Prior to coming to Vanhouse she had spent more than a year in another treatment facility. Her behavior was often quite controlling and manipulative and she had a knack for setting herself up in opposition to the staff's requests and expectations.

In the weekly discussions the staff came to the conclusion that Shannon was quite proficient at proving how much of a "failure" she can be. She seemed determined to choose behavior that would get her in trouble and encouraged her peers to do the same. Information from family therapy sessions revealed that Shannon played a similar role in her family of origin. This role is often called the "black sheep", and in Shannon's
family her behavior contrasted sharply with that of her older, more responsible sister.

**Intervention**

In formulating an intervention the staff thought it might be helpful to draw attention to the role that Shannon played within her family and at the treatment home. The following message was delivered:

"Why do you spend so much time and work so hard at trying to convince us what a fuck-up you are?"

Shannon's initial response was, "I'm not as fucked-up as I used to be!"

**Analysis**

There are a few things worth noting about this intervention. First of all the message implicitly suggested that the problematic behavior was purposeful and under Shannon's control. By framing the behavior in this way, it was hoped that Shannon would begin to question the motives for her behavior. She might even begin to put the pieces together and achieve some awareness of how the family system has influenced her behavior.
Secondly the message reframes the process by which the label of "fuck-up" has been attributed to Shannon. Presumably from Shannon's point of view it is others, specifically adults, who have labelled her as the "black sheep". The message, however, suggests that the process has worked the other way around, with Shannon trying to prove to others that she is a failure. Additionally, the use of the word "convince" in the message suggests that the staff do not consider Shannon to be a failure.

An important point should be made here in reference to the language used in this message. When formulating messages it is essential that the language chosen makes sense to the resident. The term "fuck-up" was language that Shannon would use to describe someone who consistently misbehaved. Since the wording of the message is crucial in determining its eventual impact on the resident, language that matches the world view of the recipient should be used. If, for example, the message had stated; "why do you try so hard to convince us how much of a behavior problem you are?", then Shannon would most likely interpret the message as simply another rejection by adult authority figures. Palazzoli et al. (1978), and Weeks and L'Abate (1982) also stress the importance of using language that matches the client's world view.
Again the most important aspect of this message is the way in which it reframed Shannon's behavior as voluntary and purposeful with her working to "convince" the staff that she was a failure.

Case Example #5 - Tina

History and Presenting Problem

Tina was first placed at Vanhouse in December of 1986. Prior to her arrival she had spent some time in a number of assessment and treatment facilities. Tina's mother was described as a "highly volatile" woman and her relationship with Tina was up and down, with Tina returning home for brief intervals before coming to Vanhouse. Tina's behavior was characterized as self-destructive and she displayed a low tolerance for frustration. She was often demanding and verbally aggressive with staff. On a couple of occasions she had become physically aggressive with staff. She was 14 years old when first placed at Vanhouse.

Intervention

When discussing Tina's behavior the staff were struck by the "tough exterior" that she displayed. In family therapy
sessions it was discovered that Tina's explosive mother also displayed a tough exterior. The staff hypothesized that Tina's "toughness" served a self-protective function, masking a vulnerable and sensitive side which she had difficulty exposing. The following intervention was delivered to reframe her behavior in a positive light:

"We have noticed that you act tough sometimes and we can understand it because it is probably your way of dealing with the sadness that you have."

Tina's initial response was one of confusion and she asked for the message to be repeated.

Analysis

The basic goal of this message is to reframe the behavior so that Tina might achieve some insight into her constricting "tough" behavior. The choice of the word "act" in the message suggests that Tina's behavior is put on to achieve some effect. The message was made more powerful by telling Tina that "we", the staff, "have noticed", instead of stating that the observation was made by one person.
Discussion

The message communicated to Tina that the staff understood her need to protect herself from the pain in her life. It is quite common for adolescents who have spent time going from one resource to another and who have had stormy relationships with their parents to present a tough exterior and avoid establishing relationships with others. Positively connoting this protective function would hopefully free Tina up to try out some new, more rewarding behaviors.

In the weeks that followed the delivery of this message it was observed that Tina seemed more at ease exposing her more sensitive side to others. On those occasions when Tina would act tough, staff would casually mention her need to present herself that way and this seemed to effectively defuse her aggressive behavior.

In all of the above examples the symptomatic behavior is reframed and in some cases prescribed. Reframing serves the function of altering the meaning of the symptom in order that behavioral change will follow. Once the meaning of the symptom has been altered then it no longer makes sense within the previously established context. For example, the adolescent who is determined to oppose and rebel against those in
authority positions is unlikely to do so if the authority figures accept and even prescribe the oppositional behavior.

On another level these interventions communicate to the resident that the staff respects the resident's "need" to behave in whatever way they are behaving. If the resident is accepted for who they presently "are", then hopefully they will be able to further develop and experiment with new, more rewarding behaviors.

An important element of the interventions used at Vanhouse was the use of messages which reflect the behavior exhibited by the residents both within the treatment home and within their family system. By having access to the information provided from family therapy sessions, the staff were more than adequately equipped to formulate interventions that "captured" the residents' behavior within the family and treatment environments. In the concluding chapter some thoughts on how to improve the effectiveness of systemic work within the residential treatment environment will be provided.
The purpose of this chapter is to make some general statements of conclusion concerning the treatment approach that was introduced at the Vanhouse residence. These statements function to broaden the theory of a strategic/systemic approach to residential treatment and hopefully will guide future investigators and practitioners in their work.

The four issues, or "roadblocks" to effective residential treatment, which were identified in the introduction, provide us with an excellent theoretical backdrop on which to examine the relative success of the Vanhouse treatment approach. Success, here, is measured against the theoretical propositions suggested by the corresponding literature, and not by a quantitative analysis of behavioral change in the residents. Some suggestions for specific improvements and adjustments to a strategic/systemic approach to residential treatment will also be provided in this chapter.

The first theoretical problem, which was identified in the introductory chapter, concerns the "Identified Patient" concept. When the adolescent is singled out as the problem and is placed in care, there is an implicit message that the family problems can be resolved by curing the I.P. in isolation from
the family unit. As was stated earlier, from a systemic perspective, the problem is an interactive one, involving the whole family unit. Any attempt to treat the individual in isolation is likely to be ineffective and may even exacerbate the situation.

To address this I.P. problem the Vanhouse approach included family therapy sessions as part of the program. The purpose of these sessions was to introduce change at the "family system" level. By enlisting the support of the parents the staff hoped to move the focus of the problem from the identified adolescent to the family as a dysfunctional unit. Unfortunately many of the residents' families failed to show up for their scheduled meetings. In some cases the resident's parents refused to cooperate with treatment until they were satisfied that their daughter had shown some improvement in her behaviour. Of course, without the family's involvement, the resident's view of herself as the cause of the problem is consolidated and her behavior is likely to continue to deteriorate.

One possible strategy to increase the family's attendance record for therapy sessions would be to contract for a number of specified sessions at the time of initial placement. By stressing the importance of the family's participation in the
treatment process and agreeing on, perhaps, ten sessions, a cooperative relationship would be established between the family and the treatment team.

In an effort to counter the I.P. problem and to encourage the participation of the family, Menses and Durrant (1987) stress the importance of framing placement as a positive step in the family's treatment process. They suggest that the residential staff frame the placement as a rite of passage, which marks the change of context to one in which the family is able to stand up to the problem together. The incorporation of treatment strategies, such as the above, may have contributed to a more positive working relationship between the staff and the residents' families at Vanhouse. As it was, the family's involvement in the treatment process was lacking somewhat and, as a result, the perception of the resident as the "identified patient" was strengthened.

The second "test" of the treatment approach, which was identified in the introduction, has to do with the surrogate parent issue. As was stated earlier, placement may exacerbate the "problem" by disturbing the natural process of separation and attachment that occurs during an adolescent's development. If the staff take on a surrogate parent role, then they may act to block the interaction that would eventually occur between
the family and the adolescent. In other words, if the staff provide the adolescent's need for intimacy, then there is less likelihood that the adolescent will put in the required effort to resolve the family disturbance.

As was described in the Results chapter, the staff's first attempted solution for resolving the surrogate parent problem proved to be unsuccessful. This solution involved the staff "backing off" from the development of close, dependent relationships with the residents and discretely encouraging the residents' interaction with their family. It was hypothesized that this strategic policy resulted in a "backlash effect", where the residents reacted in an angry manner to the now more distant staff.

To counter this "backlash effect" the staff provided a relationship which they felt was a compromise between their two previous positions. Ideally, the staff hoped to provide a relationship which was relatively supportive and engaging, while leaving the residents the necessary "space" to interact with their family. From both a practical and theoretical standpoint this compromise position seems to be the most advantageous way to resolve this staff-resident relationship issue. However, it should be noted that each staff member has their own individual way of interacting with residents and, as
a result, it can be difficult to establish a uniform approach to staff-resident relationships. One recommendation is to have the supervisor monitor staff-resident relationships and intervene whenever he or she feels that a staff member is behaving in an overly engaging or overly distant manner with a resident. It is important that the manner of interaction between staff and resident fall within certain agreed-upon parameters in order to avoid problems such as coalitions, favoritism and scapegoating.

Perry et al. (1984) discuss the problems of triangulation that can occur between the adolescent, the staff, and the adolescent's family. In their paper they identify a number of separation and attachment issues that can complicate the residential treatment situation. Essentially, their primary concern is the disempowering effect that residential placement has on the integrity of the family unit. To minimize the counter-therapeutic aspects of treatment in isolation from the family, they suggest the following:

1) the program should serve only as a catalyst to energize the relationship between the family and the resident.

2) the program should best reflect a quality of non-attached nurturance and unconditional family empowerment.

3) no matter what state the family relationship is in, the resident should be unconditionally
supported for having as much possible connection and support from family.

4) staff's role should be to unrelentingly confront the family with their responsibility and value to the resident's well-being.

5) the family should be involved in the treatment plan and should be invited to participate in activities in the house, as well as attend regular family therapy sessions. (pps. 23-24)

These suggestions are, to a great extent, in accordance with the strategic/systemic approach that developed at Vanhouse. However, in regards to supporting residents in their interaction with family members, the Vanhouse staff took a more neutral position than the one suggested by Perry et al. (1984). At Vanhouse the policy was to neither encourage nor discourage family contact. It was thought that by remaining neutral the residents were best able to decide for themselves if, and when, they were ready for family contact.

In regards to family involvement in the treatment process, the residents' families at Vanhouse were not as actively involved as Perry et al. (1984) recommended. On occasion the parents were consulted about minor treatment issues like curfew times and clothing expenses, but, on the whole, they were minimally involved in the on-going process. From the author's point of view, as a participant observer, a more engaging and cooperative relationship with the residents' parents would have likely increased the overall effectiveness of the approach.
The neutral, passive role that the Vanhouse staff assumed may have been interpreted by the parents as a message that their participation was not expected or desired.

The third issue that the Vanhouse staff had to address involved the problem of client resistance to change or treatment. As was described in the Results chapter, resistance was dealt with by 1) avoiding the assumption of an overpowering or highly directive role in relation to the residents, 2) avoiding the assumption of an "us and them" or adversarial role between the staff and the residents as a group, and 3) using strategic/systemic interventions as the predominant treatment method.

In reference to the first method for dealing with resistance, the staff avoided taking on a highly directive role and communicated to the residents that they, themselves, were the only ones who could decide what was best for them. By doing so the staff were hoping to avoid the situation where the adolescent feels powerless and proceeds to oppose anyone in a position of authority or guardianship. Underlying this empowering strategy was the belief that the adolescents would begin to develop self-imposed limits on their inappropriate behaviour. In a study such as this it is impossible to determine conclusively whether this dynamic actually occurred.
From Redl's (1952) theoretical standpoint, which is described in detail in the Review chapter, it is questionable whether adolescents from dysfunctional families would have the necessary "ego strength" to self-impose limits on their inappropriate impulses. It is possible that some of the residents' unpredictable, out-of-control behavior could have been better managed, both in a practical and therapeutic sense, by applying more directive force.

The author's opinion on the above issue is that an empowering strategy can be a very effective therapeutic tool if used with adolescents who are developmentally ready to assume responsibility for their behavior. On the other hand, if the staff give up too much perceived control to a resident who is not ready to receive it, then they may act to increase the adolescent's out-of-control behavior. The situation may be analogous to the "omnipotent child" dynamics, where the child presumably acts out as a means for probing the limits of his or her personal power. In the residential setting, then, some adolescents may be too immature to benefit from messages that they, themselves, are the only ones who can decide what is best for them. For these adolescents the imposition of limits from the "outside" may be necessary before any self-imposed limits are possible.
To make the above discussion more concrete, a couple of specific examples from Vanhouse may be helpful. The first example involves a 16 year old girl who presented with complaints of depression and problems associated with alcohol abuse. Initially she displayed highly dependent behavior with the staff and tended to dramatize her "depressive" behavior. She was keen on relating her many, varied problems to staff and actively sought others' advice. In response, the staff consistently framed her "depression" as sadness and positively connoted its expression. In addition, the staff repeatedly conveyed the message that she was the only one who could initiate any changes in her behavior. Essentially it was communicated to her that she was the only one who had the power to limit and alter her own behavior.

Over the next couple of months, it was observed that the above resident's behavior improved significantly. She appeared less "depressed" and seemed to be imposing more appropriate limits on her previously erratic behavior. The message of empowerment appeared to be successful in as much as she was beginning to take responsibility for her own behavior.

The second example involves a thirteen year old whose presenting problems included an explosive relationship with her mother and numerous "acting-out" incidents that may be
categorized as rebellious and immature. In keeping with the Vanhouse strategy of dealing with resistance and avoiding a power struggle, the staff communicated to the resident that she was really the only one who could effectively put limits on her own behavior. The staff refrained from applying strict consequences to her inappropriate behavior and insisted that the resident make her own "responsible" decisions. In this case the "empowering" strategy seemed to backfire, as the resident's behavior became increasingly problematic throughout her placement. On a number of occasions she was verbally abusive with staff members and her outbursts escalated to the point where she was physically striking out at the staff.

The difference in the two examples reported above may be attributed to the residents' respective maturity or developmental stage. In the first example, with the older adolescent who tended to look to others for guidance, the empowering message and the lack of strict controls served an appropriate function. She was at the developmental stage where guidance and limits imposed from the "outside" would have contributed to her dependent, "irresponsible" behavior. However, in the second example the message of "empowerment" and the assertion that the staff were really powerless to effect any behavioral change, likely exacerbated the 13 year old's feeling of being "out-of-control" and contributed to her need
to display reckless behavior. It might have been more effective, with the more immature resident, for staff to impose firm limits on her behavior until she was developmentally "ready" to impose her own limits. In conclusion, then, the strategy and messages communicated to each resident should be matched to the specific developmental stage that they have reached. A "blanket policy" to deal with resistance and limit setting is not recommended when working with adolescents who are at various stages in their developmental maturity.

In regards to the second method for dealing with client resistance, that encountered when the residents band together and view the home as a staff vs. residents situation, there is little more to report. Strategies that avoided sanctioning the residents as a group seemed to adequately address this potential problem. Group meetings also provided a good opportunity to discuss and defuse any growing feelings of hostility towards the staff. The third method of dealing with resistance, the use of strategic/systemic interventions, will be discussed in detail shortly.

The last problem, or roadblock, associated with residential treatment is concerned with the necessity that staff manage the inappropriate behavior of the residents. The issue that arises here is to what extent the staff's
therapeutic role is jeopardized when they are required to assume a position of authority and control in the home. The solution to this issue can be found in the previous discussion. For those adolescents who are developmentally at a stage where they are ready to impose their own limits and take on more responsibility, the staff's most advantageous therapeutic role is to back-off from the authoritative stance. For those adolescents who have not yet reached the developmental stage where they can assume responsibility for their own behavior, the staff's therapeutic role necessarily involves assuming an authoritative stance. In other words, for adolescents who are developmentally immature when it comes to self-control, the staff's therapeutic role is not jeopardized by assuming an authoritative stance. On the contrary, it is suggested that for the immature adolescent, the staff's most therapeutic strategy is to provide the resident with a firm, clearly defined authoritative relationship.

The most unique, and in many ways the most important, element of the Vanhouse approach were the strategic/systemic interventions or messages. These messages were "targeted" at specific behaviors of the residents and, in most cases, functioned to reframe the maladaptive behavior. From the various interventions utilized at Vanhouse, positive connotation and prescribing the symptom seemed to be the most
effective. This conclusion is based simply on the observed responses of the residents and the opinions held by the staff members.

Positive connotation appeared to be an effective way of "joining" with the resident. By accepting that the problematic behavior served some positive function for the resident, the staff were able to assume a role that distinguished them from the typical authority figure. In some cases, however, the residents continued to be antagonistic and oppositional with the staff, and escalated their provocative behavior as an invitation for control.

One controversial issue that arose concerning the use of positive connotation, centers on the question of whether this type of message can be misinterpreted. Positive connotation acts both to; 1) reframe the meaning of the behavior, and 2) place the staff in a neutral, or "positive" position, in relation to the symptomatic behavior. Although the explicit message of the intervention positively reframes the symptomatic behavior, the overall goal of the intervention is, obviously, to limit the expression of that behavior. In some cases the resident can easily perceive both the positive and negative aspects of an identified behavior. For example, if the staff tell a resident that crying alone in her room is a good thing,
then the negative aspects of the positively connoted behavior would most likely be evident to the resident. In other words, although she may begin to see that the behavior may have a positive function, she also must feel that she does not want to cry for too much longer. In other cases the negative aspects of some identified presenting problem may not be as evident to the resident. For example, if a resident is staying out late past her curfew repeatedly, she may not perceive any drawbacks to this behavior when it is positively connoted. In this case, positive connotation would not function to reframe the meaning of the behavior.

If the behavior in question has not been reframed for the resident, due to the fact that the resident cannot perceive any negative aspects to it, then positive connotation may exacerbate the problem by actually increasing the expression of the symptom. To avoid this problem, a message of positive connotation can be formulated in such a way that the negative consequences of the behavior are also spelled out by the staff. For example, the message might go as follows:

"The staff have noticed how difficult it is for you lately to return on time for curfew. We understand that you are making friends out there and we think that's great. However you are having trouble getting up in the morning and your school work is probably suffering from lack of sleep. Do you think you can still see your friends and make it in for curfew?"
This type of message positively connotes the intention of the behavior, making friends, while pointing out some of the negative consequences of staying out too late. In conclusion, then, for certain behaviors, where the negative aspects of the behavior are not self-evident to the resident, the message should contain both the positive and negative consequences of the identified behavior.

Another intervention at Vanhouse which appeared quite promising was "prescribing the symptom". When a symptom was prescribed the resident was encouraged by the staff to display some behavior which would usually be considered undesirable. Some examples of behaviors that were prescribed include; depression, frustration, anxiety, anger and sleeping difficulties. Theoretically, once the behavior is prescribed, the resident should have difficulty spontaneously expressing it. Prescribing the symptom suggests that, to some extent, the behavior is under voluntary control.

One of the common reasons for prescribing the symptom at Vanhouse was to provide the residents with an acceptable explanation for their dysfunctional behavior. The Vanhouse staff were of the opinion that although the residents regularly defended and denied that their behavior was a cause for concern, they were inwardly confused and disturbed by their own
actions. The staff hoped that by attributing a benign motive to the inappropriate behavior, the resident would begin to feel more at ease and less guilt-ridden. For example, a resident might be directed to continue arguing with staff because this would help to relieve some of the tensions coming from her unresolved family situation. As we can see, the motive attributed to the behavior is an acceptable one; anxiety, and the resident is given permission to express it. The goal, of course, is that once the resident has been given permission to display the behavior, and the behavior has been attributed a benign motive, the resident will feel less compelled to display that behavior.

Aside from the question of how or why the interventions used at Vanhouse were effective, more often than not, the messages appeared to have a positive therapeutic impact. In those cases where the messages seemed to have little or no effect, it may be hypothesized that the following elements were lacking:

1) the message was not matched with the developmental level of the resident.

2) the way in which the message was delivered underscored its impact, i.e. a more "formal" presentation may have been more effective.

3) the language used in the message did not "match" the resident to whom it was being delivered, i.e. the specific words chosen were not suited to the adolescent's world view.
4) and, finally, the specific strategy chosen was off "target", i.e. the message failed to capture the significant dynamics of the situation.

Another important concept related to formulating interventions has been described by Bergman (1980). Bergman suggests that symptoms displayed by residents serve some function for them and are maintained by the emotional system within the community home. He also introduces the concept of "context replication", suggesting that the symptoms that the resident displays in the treatment home may have served a similar function when the resident was living with his or her family of origin. Observations at Vanhouse definitely support the hypothesis that symptomatic behaviors which originated in the family context, are "reenacted", in one form or another, in the residential setting. It is suggested further, by the present author, that these "reenacted" behaviors should be the primary "target" for strategic/systemic interventions.

The reason why these "reenacted" behaviors are of critical importance has to do with the fundamental treatment goal. This goal is to alter the dysfunctional behavior of the resident's family as a unit, in order that the resident may eventually return to that family. Those behaviors which are replicated in the treatment context are manifestations of the family dysfunction. By focusing on these behaviors, the resident's
In order to formulate successful interventions; those that target "reenacted" behaviors, it is essential that the staff have a good knowledge of the family history and dynamics. This knowledge comes from the previous written histories on the families and the information gathered by the family workers. For this reason, good communication between the family workers and the rest of the treatment staff is a necessity. It is suggested that to enhance this communication the child care workers should be involved, somehow, in the family therapy sessions: preferably as observers behind a one-way mirror. In addition, the family workers would benefit from day to day observations of the residents in the treatment context. By overlapping the functions of the child care workers and the family workers a more complete picture of the individual and family dynamics will be attained, and, consequently, more successful interventions should follow.

Finally, some general statements about the relative strengths and weaknesses of the Vanhouse approach to residential treatment can be made. Unlike many of the treatment approaches described in the Review chapter, the Vanhouse approach squarely addresses the problems associated
with treating an individual in isolation from the family unit. Both the relationship of the staff to the residents and the interventions utilized, sought to avoid disempowering the family unit. Also, by avoiding the assumption of an overly controlling and directive relationship with the residents the staff facilitated the natural process of developmental maturity. Some residential programs are highly directive and apply severe consequences as a means of teaching the residents "appropriate" behavior. The Vanhouse staff questioned whether behavior "learnt" under these circumstances is transferrable once the resident returns home. By "empowering" the resident to make her own decisions, and giving her room to make her own mistakes, the Vanhouse staff hoped to provide more long-lasting, transferrable behavioral change.

One of the contraindications inherent in using strategic/systemic methods in the residential setting has already been identified. This problem arose when immature adolescents escalated their provocative behavior, presumably, as a result of a lack of staff control and discipline. Immature adolescents, who are not ready to assume responsibility for their behavior, may require more pronounced control and discipline before they are ready to receive less. Another problem that was encountered at Vanhouse involved the staff members' attitude toward the approach. Some of the
workers questioned whether the new changes to the program would be effective and, as a result, their support was lacking. Needless to say, without full support from the staff, the treatment approach suffered and the residents became aware of a lack of enthusiasm on the staff's part. This kind of issue is best dealt with by holding meetings and resolving any differences between the staff members.

In reference to the traditional theories of residential treatment described in the Literature Review chapter, some comparisons and contrasting issues are noteworthy. As with both the psychoanalytic and behavioral approaches, the Vanhouse approach acknowledged the importance of the "total treatment environment". The rules, routines, activities, staff/child interactions and architecture of the treatment environment were all taken into account as important ingredients of the treatment approach. It may be said that the Vanhouse treatment approach emphasized the importance of the front line worker, or child care worker, to a greater extent than any of the traditional approaches to residential treatment. By incorporating strategic/systemic interventions into their day to day contact with residents the staff hoped to encourage behavioral change at the staff/resident interactional level.
Behavioral change was also encouraged at the family system level by providing family therapy sessions. In order to avoid a separation between the family therapy and the on-going child care work, the family therapists participated in the weekly staff meetings. Unlike the traditional approaches described earlier, the Vanhouse approach underlined the importance of using information from family therapy sessions in the formulation and delivery of residential treatment interventions. The incorporation of family therapy, and the use of information from family therapy sessions in the on-going treatment, are two aspects of the Vanhouse approach which clearly distinguish it from the traditional residential treatment approaches.

As has been stated previously, most residential treatment philosophies suggest that a nurturing, supportive relationship is a key ingredient of therapeutic success (Bettelheim, 1974; Jones, 1980; Brendtro & Ness, 1983). A behavioral approach to residential treatment concluded, upon attempting a replication of a behavioral treatment home, that their system could only work in the context of a warm, open and giving interaction between staff and residents (Phillips et al., 1973a). The staff at Vanhouse also concluded that their approach was viable only if they provided a relatively engaging relationship with the residents. However, the Vanhouse approach suggests that
this crucial relationship should be less intimate and involved than the relationship that may develop in some of the traditional approaches to residential treatment.

The policy that the Vanhouse approach held in relation to "symptom tolerance" also distinguishes it from many of the traditional approaches. Many of the symptoms that the residents displayed at Vanhouse were tolerated and allowed to come out in the open. There were two significant reasons for tolerating symptom expression; 1) by presenting a tolerant atmosphere the staff were able to more accurately assess the "true" behavior of the residents, and 2) with the symptoms out in the open the staff were in a better position to manipulate them for treatment purposes; i.e., once a symptom has been displayed the staff are in a position to positively connote or prescribe it. Some treatment approaches attempt to alter behavior by applying strict consequences to inappropriate behavior and by providing the residents with a structural program. The Vanhouse staff were of the opinion that excessive "artificial", staff induced constraints and limitations fail to encourage any long-lasting behavioral change. For this reason, a more tolerant, strategic approach was used to address the issue of symptom expression.
In conclusion, the implementation of strategic/systemic methods into the approach at Vanhouse was an exciting and innovative experiment in the residential treatment of adolescents. The results presented in this thesis suggest that these methods may contribute significantly to a general theory of strategic/systemic residential treatment. In many ways the work at Vanhouse should be considered a pioneering attempt at uncovering the inherent complications and advantages of providing residential treatment from a systemic perspective. Hopefully this thesis will act as a catalyst for others who wish to pursue a more complete theory of strategic/systemic residential treatment.


