McClure, Mallory & Baron
EDUCATIONAL COUNSELING AND PLANNING

Therapeutic School Placement: Parallel Processes of Change in Children and Their Parents

By Molly Baron, M.A.

When I was invited to speak at a NATSAP member's Family Weekend, I knew instantly what I wanted to talk about – The Stages in the Process of Psychological Change - in a therapeutic setting such as this program / school. I chose to focus on the parallel experiences of parents and their children during the difficult process of placing a child in a therapeutic school. Granted that each child and family is unique, there are, nevertheless, goals that are common to nearly every adolescent client I encounter.

Developmental Milestones:

For all adolescents there are certain developmental milestones that are critical to their successful transition to young adulthood. Whether as a result of family conflict, mood disorder, learning disability or substance abuse (or some combination thereof), many of my clients have stepped out of the "developmental mainstream." As a result, their capacity to tolerate frustration, delay gratification, resolve conflict, and sustain reciprocal relationships is impaired. I consider the achievement of age-appropriate, developmental maturity a primary goal of placement in a therapeutic setting.

Self-Care & Care for Others: Two aspects of maturation are the capacity to care for oneself and, perhaps more importantly, for others. Self-care, including establishing appropriate boundaries, accessing and expressing feelings in a healthy manner, and setting and achieving meaningful personal objectives is an important aspect and measure of adolescent health. Similarly, the ability to care for others, in a balanced and empathetic way, without either sacrificing one's own integrity or relying on manipulation in order to fulfill one's needs, is an essential objective of the therapeutic process for adolescents. No small task, eh? When I talk about placement in these terms with parents in my office, their heads nod rapidly, a non-verbal acknowledgement that, "This is exactly what my child needs!" There is often a simultaneous expression of incredulity; "Is this actually possible?"

200 Lombard Street • San Francisco • California • 94111-1113
phone: 415.421.4177 fax: 415.421.4183 email: general@mmbedu.com

Parental Alignment: That question, or some variation, creates the opening for what, I believe, is the most important conversation I have with parents about placement. In my opinion there are two critical criteria that are essential for successful outcomes. First, the parents must be aligned with each other. It matters little whether the parents are married, divorced or none of the above. What matters is that they are able to function as a team in communicating to their child that, while they may differ on many issues, there is no disagreement about the need for treatment and their commitment to the process. The second, and equally important criteria, is that the parents must be aligned with the program. Many children in distress have learned and mastered the maladaptive art of manipulation. If they are to learn healthier and more effective ways of getting their needs met, their ability to use the old, dysfunctional techniques must be blocked by the united front of parents, therapists, team leaders, residential staff and teachers.

So, to the matter at hand…how does this process of change occur and what are the typical stages in this process?

Stage 1: The Leap of Faith

For the adolescent and parents alike these first steps in treatment echo the earliest years of development, as they require the reestablishment of trust. Trust in those professionals involved in the treatment process, which requires nothing short of a leap of faith; trust that, despite the painful twists and turns their relationship has taken, there is still an underlying bond of love between parent and child. In my experience the first stage lasts, on average, about one to three months. There are a number of factors that impact the amount of time a particular stage lasts; was there an initial intervention such as a therapeutic wilderness program, how severe is the symptomatology, and what is the intensity of the therapeutic intervention?

Although this discussion is primarily oriented toward the parent-child experience of treatment, the professionals involved need to remind themselves with each new family that while this may be the fiftieth or hundredth or thousandth client for them, it is the first experience of this intense process for this family. That sensitivity needs to infuse each contact, each recommendation, and each intervention. It is that personal connection to each child and family that allows a sense of trust to be generated and the resistance to change can begin to ebb.

However long the initial period lasts, there are certain common experiences for students and parents. Most adolescents, confronted with a novel setting, will run through their repertoire of coping strategies – anger, manipulation, withdrawal, etc. Their letters and phone calls often contain threats: “if you don’t get me out of here, you’ll never see your grandchildren;” regrets: “I’m so sorry for all the pain I’ve caused you;” promises: “I’m ready to work on my issues;” manipulation: “but I need to be at home so we can work through our issues together;” confidence undermining: “I’m not like the other kids here – they are heroin addicts and juvenile delinquents.” The point is, children are exquisitely aware of what pushes parental “buttons” and, as long as activating those triggers has the desired outcome (parental uncertainty, rescuing, guilt, etc.), the child does not have to learn the new coping strategies. By frustrating the effectiveness of those old strategies, a motivation is generated to learn new and healthier means of getting their needs met.

Parents, during the initial phase, are asked to endure their child’s pain and frustration. It is possibly the most difficult thing for a parent to do. From infancy we have rushed to ameliorate a child’s pain, anger, frustration. There comes a time, however, when parents must gradually remove themselves as the arbiter of their child’s discomfort if the child is to develop his or her own capacity to interact directly and effectively with the world. The first couple of months of placement can feel like a crash course in enduring a child’s pain and frustration without rushing in to fix or rescue. Many parent experience a conflicting range of emotions at this time: guilt, grief, and relief.

Guilt: Sometimes they come in rapid succession; at other times, parents experience these difficult emotions all at once, wondering if it is the myriad of their mistakes and miscalculations that has created this painful situation, they are paralyzed by guilt. While guilt may be a legitimate, even healthy response, it should not be the basis for making decisions about how to respond to a child’s distress. Guilt may be most useful in motivating parents to explore their part in this process and what they may need to do to become effective agents of change in their child’s treatment.

Grief: Grief is a complex response to the loss of the dream of a child’s adolescence. Parents may have anticipated watching their child play in a championship basketball game, or dance in a jazz recital, or choose a dress or tuxedo for the prom. The sense of loss, while perhaps most intense at the beginning of placement, is an emotion which remains throughout the treatment process and, if it goes

unacknowledged or unaddressed, can at any stage undermine completion of the process. Parents may feel that it is trivial, in the light of their child's situation, to mourn a missed game or dance or holiday. As a result, they may not feel they can express those regrets. Yet it is the feelings that aren't discussed that gain power and take on a life of their own. Those involved with the family can help by encouraging parents to talk about their sense of loss and to reframe the current losses in the context of future possibilities for their child. Indeed, the overriding goal of therapeutic placement is to create the possibility of a healthy future for their child.

Relief: Oftentimes, mixed up with the guilt and grief is a surprising relief: Relief that their child is safe, relief from constant pressure of fear and worry, relief from the cycle of anger and regrets, relief from the lack of sleep and constant tension.

Stage 2: Temptation Time

I call the second phase "Temptation Time." The teenager is now eating well, sleeping well, experiencing success in school and in relationships, exercising regularly and learning to explore and express the feelings that sabotaged their progress toward emancipation. They look really good. The changes in their teenager raise the parents' hopes – "maybe things really can get better," "maybe we can have those dreams after all," "maybe we can be a family again." These are important and valid hopes, although sometimes they are fueled by the pressure that the child's absence has placed on the family system… "What do we talk about if we are not arguing/worrying about our child?" It is not unusual for the pressure of coping with an out-of-control teenager to have put incredible strain on a marriage or to have forced parents to neglect other children or responsibilities. There is a subtle temptation to bring the child home at this stage; to re-establish the familiar, albeit unhealthy status quo. It is what he/she wants; it's what you want too.

Personal Change: This is the moment when it is time to talk about what change means. In my opinion, personal change is the single most difficult process we can undertake. And it is a process in which there is no substitute for time. For most of my clients an essential goal of treatment is to move from an external locus of control (parents, teachers, the law, etc.) to an internal locus of control (their own sense of self and values). This type of lasting change occurs because the adolescents, through the treatment process, begin to alter the way they see themselves and the world. The beliefs and attitudes which drive their decisions begin to shift – being honest feels good,

completing a task creates a sense of competence, caring what someone else thinks or feels generates a feeling of connection. From this alteration in perception comes genuine change in behavior, not out of fear of punishment or due to material inducement, but because there is an internal impetus for their self-image and choices to become more congruent. In turn, these new ways of being in the world generate new experiences of efficacy and fulfillment. Each success fuels the developing sense of self-worth and the belief that things can indeed be different and better; i.e., change is possible.

Therefore, to fall prey to the temptation to bring a child home at this fragile stage is to risk short-circuiting the very process of change before there is sufficient time to internalize the new attitudes and beliefs. Parents need to hear from the treatment team a realistic assessment and appreciation for the child's and the family's progress, acknowledging the gains and outlining the challenges which remain. In this way, a new balance can take hold in the family, which lessens the temptation to return to the status quo.

The Plateau: Before discussing the third and final phase in the treatment process, I would like to talk about a common experience and a cause for concern on the part of the parents – the plateau. Rather than view periods in which no change appears to be taking place as stagnation or as a failure of the process, parents and students should be counseled to expect plateaus and regard them as opportunities to practice new skills. We may have become so habituated to moving from crisis to crisis that we fail to appreciate the lulls, the plateaus.

Stage 3: Transition

The last phase of treatment is a time to consolidate these gains. During the Transition Phase considerable pressure is placed upon the enhanced communication skills that have been a focus of treatment since the beginning. Learning to express feelings and learning to listen to others generates a sense of comfort and confidence internally and interpersonally. Moving toward a transition out of treatment places demands on these skills as student and parents negotiate the looming questions, "Now what?" What will the realization of the treatment goals – maturation, individuation, family reintegration – look like for this child and this family?

Many of the old challenges will return, although in different forms and with less potency. These renewed challenges do not signify a failure of

the process. To the contrary, they represent a fresh start, a chance to do things in a new way, in a healthier way. What are those challenges? Re-establishing trust on a day-to-day basis. Its 12:15 on a Friday night, a 17 year-old who has never been in treatment is 15 minutes late for curfew…when he gets home, his parents say, “You’re 15 minutes late. You need to be home 15 minutes early tomorrow night.” When a 17-year old who has been in a therapeutic boarding school for 18 months is 15 minutes late for curfew, his parents are trying to decide when to call the police.

Haunting Fantasies: Other challenges are those fantasies, those dreams which have “haunted” the process from the outset: “I just want to graduate with my class,” “If my son doesn’t come home for his senior year…?” Honestly, you can’t go back nor, if you think about it, do you really want to. What you can do, though, is talk about these issues and listen. You have learned to endure your child’s anger. Your child has learned to tolerate his or her frustration.

A Labor of Love: It is time to listen carefully to those who have been integral to the treatment process. You and your child have learned that his or her therapist wants what is best for your child. Trust their care and their objectivity. Together, identify the triggers that, in the past, have led to denial, avoidance, splitting or capitulation. You have both learned how to talk about difficult feelings, and you must. In this way the past does not become the future.

The process of individuation has begun and your child has regained a sense of meaning and a sense of belonging. This process of change has been incredibly hard work on the part of the child, the parents and the treatment team. But it has been a labor of love.

Molly Baron, trained as an educational and clinical psychologist, now works full-time as an educational consultant with McClure, Mallory & Baron in the San Francisco Bay area. Molly specializes in the placement of children, adolescents and young adults with therapeutic/special needs.