

A Systems Approach
to Working With Families
of Children in Residential Care

by

Gisele Toupin

A practicum
submitted to the Faculty of Graduate Studies
University of Manitoba in partial
fulfillment of the degree of
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Literature Review

The emphasis of the review is based on the premise that working with families of children in residential care is of utmost importance. Generally it is felt that parents are a critical part of the treatment process. They may be active or passive, co-operative or resistant, but their relationship to the child and the child's relationship to them, are a crucial part of the child's life and his/her pathology. Not only is the inter-relationship seen as part of the child's pathology, but it is also seen as a crucial part of the child's/family's recovery.

Problems are encountered when a member of the family, the child, is living in residential care. Historically, families were only considered as an adjunct to the child in care and involved peripherally in the child's treatment.

The notion of therapeutic (milieu) community is explored with the basic concept that the social milieu itself can be the instrument of treatment. The realization that people change, learn and mature as a result of their interpersonal and social relationships and experiences is not new. It is interwoven within all theories of personality development. These stages and theories are examined within the context of childhood disorders.

The social milieu can be re-defined by the therapeutic community and expanded to include the child's family. The

degree to which parents participate in the institutional treatment process is highly dependent on the organizational structure and philosophy of the institution. It is the responsibility of the institution to ensure parental involvement, thereby bridging the gap between the past and the future. Where the family of origin is no longer integral to the child's future, it is the institution's responsibility to convene any community supports which may be available to aid in the child's treatment.

It is all too common practice to refer a child to a residential setting with little consideration being given to the parent child interaction. The review of literature outlines various methods of working with families in therapy. Rather than assume that residential treatment will change a "bad" child to a "good" one, various methods are examined which involves the whole family in the process of change. This reduces the possibility of blaming the victim and isolating him/her from his/her family and possible solutions.

The following review of literature surveys material pertinent to child development, the care of institutionalized children, milieu therapy, families of children in care, the concepts of family therapy itself and family therapy with children in residential treatment.

Milieu Therapy

When describing a "milieu" therapeutic environment, one describes a group living situation for children, children who suffer with emotional problems. Their lives are usually filled with crisis; crisis which result in their removal from their natural homes.

A very important component of the therapeutic milieu is the fact that the life processes of these children are carefully considered and focused upon. Staff in the therapeutic milieu use the children's life events and life processes as an "effective tool" to help the children (Trieschman, A.E. et al, 1969).

Children are placed in a therapeutic milieu so that, with help, they can change their behavior. Changes in behavior also include intellectual and emotional aspects of childhood as well as actions or observable behavior. Changes as a result of maturation and growth are also encouraged and supported.

It is felt that some children need help to stop or reduce deviant, dangerous, and/or age-inappropriate behavior. The goal is to develop adaptive, productive, age-appropriate behavior.

Milieu therapy was utilized as early as 1920 when August Aichorn first developed the concept as a tool to treat delinquents. Later (1955) he wrote about the tailoring of the environment to individual needs as

understood through psychoanalytic insights into individual children.

Trieschman (1969) felt that the growing ego needed to develop an array of behaviors associated with feeling and ideas that could deal with the environment in such a way as to satisfy impulses. At the same time, the child has to develop a sense of competence in dealing with people, things and events.

Erik Erikson (1950) outlines large areas of emotional and developmental skills that children need to learn. At each developmental stage are issues which children need to address as part of their normal growth.

The first issues, Oral Stage Issues, relate to basic trust. Within this stage a balance must be struck between the capacity to trust and mistrust. The child must develop a sense of being able to get (from mother) and be able to give (satisfaction to mother).

During the second stage, the Anal Stage, a balance of autonomy over shame or doubt must be resolved. The child must develop a sense of bodily control and self-management. She/he must be able to create a capacity to affect his/her parents and be affected by them. Part of this process is the development of communication skills.

The Oedipal Stage is characterized by a balance of initiative over guilt, a sense of role in the family vis-a-vis the child's mother and father figures. Following this

stage is the Latency Stage when the child develops a balance of industry over inferiority modifying social learning (eg. sharing), precision learning skills (eg. reading and arithmetic) and the capacity to work at something.

The fifth and final stage is labeled the Genital Stage and the issues resolved during that period relate to the development of identity. At this time a child acquires a workable identity rather than a sense of self diffusion. The child defines his own social entity as well as sexual identity during this period.

Children in residential treatment milieus often have "defective egos" in that some of these specific developmental tasks have been poorly resolved. As a result, it is necessary to teach alternative behaviors leading to a better resolution of the developmental tasks. It is felt that by using this method, the ego is strengthened and has a capacity to solve problems by way of moving children along the developmental scale. This teaching capacity can hopefully increase the child's knowledge of his/her problem and provide an alternate and healthier way of relating.

One very important aspect of ego development is the development of a capacity to deal with feelings. The ability to cope with and use anger, frustration, sadness, longing, excitement and joy is often missing in the emotionally disturbed children found in these settings. The aim of the milieu treatment process is to utilize the

child's feelings and experience as tools in order to teach them that there are positive alternative behaviors in response to their real feelings.

Parent Involvement

One of the major questions confronting therapists in a residential treatment centre is the degree and kind of continuing relationship a child should have with his/her parents while he/she is in the centre. In some cases it has been seen necessary to not only separate the child from his/her parents, but even to prohibit temporary visits, phone calls or correspondence.

Generally it is felt that parents are a critical part of the treatment process. They may be active or passive, cooperative or resistant, but their relationship to the child and the child's relationship to them, are a crucial part of the child's life and of his/her pathology. Not only is the inter-relationship between the child and his/her parents seen as a crucial part of the child's pathology, but also as a part of the child's recovery. Mayer (1971) felt that the parent's acceptance to the treatment plan may mean the difference between success or failure of the treatment. This means the adaption of the parent's actions to the treatment plan as well as joint planning for all meaningful interactions.

Parent involvement also implies that the parents review

their own past and their present roles in the child's development. For some parents it means that they themselves have to undergo therapy and achieve some change in their own mode of living and interaction.

There are some parents who are unable or unwilling to involve themselves in any process of self-examination and change. It is Mayer's (1971) opinion that in cases such as this that it is very questionable whether the child can return to such a home without risking occurrence of the original conflict.

Frank (1965) suggests that childhood disorders are a direct outgrowth of poor parenting and that disturbed states of children correlate with ineffective, overly rejecting, or over-protecting parents. Such links have not been established despite one's intuitive feelings that the emotional relationships within a family can have a decisive effect on the personality a child develops. VanderVeen and Novak (1974) have suggested that it is the perceived family interaction that affects children and contributes to their maladaptive behavior.

Initially, parents were involved only minimally in the therapeutic process of helping trouble children. As early as 1917, Mary Richmond insisted the family be involved in diagnosing children's problems. In 1934, Healy insisted that parents be interviewed to obtain developmental information to aid in the formulation of the problem. The

involvement of parents in the helping process created the team approach which became a permanent fixture in child guidance by 1924. At this point, parents became involved as providers of information and receivers of advice. An important shift later emerged which allowed the parents to involve themselves in the therapeutic process. It had become clear that parents could not alter their behavior and attitudes unless they took an active part. Giving advice and sharing information was just not enough.

The temptation has been in the past to keep parents at arm's length, which is easily done when the child is contained in a residential setting. The staff would observe the "relapses" experienced by the children after family visits and/or correspondence. Childcare staff often competed with and felt resentment towards the parents. Some parents also had a tendency to project their own shortcomings onto the staff of the institution. This may have led to conflict between the family and the institution which finally resulted in a total abandonment of the treatment plan. The parents may have feelings of being powerless and emasculated by the institution and this, no doubt, aggravates the situation between the parent and the child. Mayer feels that this is a result of the institution's uncertainty as to whether and when to treat parents as patients, clients or collaborators in the treatment process.

One of the most complicated tasks of residential treatment is to help both parties to see each other realistically, and at the same time to establish an affectionate and affirmative relationship. The quantity and quality of the child's interactions with his parents are an essential part of the treatment process itself. Even if the parents cannot play constructive roles in the child's treatment and cannot become partners in the treatment team, it is better if some role can be found, if some participation is possible. It is felt that total separation of parents from children makes treatment a much more complicated and aimless process for both.

Often it is the case that children should have been placed in residential treatment earlier than they actually were. Parents had made many futile attempts at other forms of treatment and had unrealistic expectations. The delays in treatment may have aggravated the pathology and reduced the chances of success in residential treatment. Bloch and Behrens (1959) found that many children who were treated unsuccessfully for many years and finally referred for residential treatment, could not live in their own homes and need some other placement facility following treatment.

Minuchin (1967), in working with delinquent boys from poor families, found that in 75% of their cases there was no stable father figure. When the father was present, he completely deferred to the mother in the matter of child

rearing and education. At the same time, the mother looked upon her role primarily in nurturing terms and, therefore, communicated ineffectualness when she needed to guide or control the children. Inevitably, both parents felt themselves powerless as the children took control. They even hastened the process of premature independence in children by insisting on their being autonomous, i.e. without the need for parental guidance or by vesting authority in an older sibling.

Minuchin states that in these types of cases that the therapist should concern himself/herself with the various behavior patterns and guide the family members to examine their inability to solve problems. Minuchin also felt that it was imperative to familiarize oneself with whatever support system of indigenous resources which operate in the family's immediate environment. Maximizing the resources available to the family members could only help to increase the chances of solving their problems.

Families of Children in Residential Treatment

The parents of children in residential treatment have been involved in the treatment of their child while he/she was still in the community. They have had to struggle with the acceptance of treatment and have had to surrender their authority over the child to various therapists. As part of a therapeutic intervention they may have had to make

significant changes in their life-styles. They have also had to submit the power to make decisions regarding the frequency or duration of therapy to the therapist.

Very often treatment in the home has been discontinued because one or both of the parents could not accept the surrender of authority. In residential treatment, however, there is an even greater surrender of control. Parents actually have to give up the child and the institution is left to determine the participation of the parents.

Institutions have aimed their work with parents at reassuring them that their authority will remain intact in the future. Parents have been assured that the surrender of their authority is only temporary and the more certain parents were of their ability to resume their parental role in the future, the more ready they usually were to surrender their authority in the present.

Mayer (1972) emphasized that the degree in which parents can participate in the institutional treatment process and exercise some part of their parental function depended on the organizational structure of the institution and its philosophy. Wilner describes how some institutions have been creative in simulating parents' constructive participation while the child is in placement. It is felt that it is the institution's responsibility to involve the parents' participation by assuring regular visits and correspondence. Ultimately, it is the institution's

responsibility to prepare the parents for the eventual resumption of parental authority.

For the child it is very difficult to understand why his/her parents have placed him in an institution. He/she may feel that they have "given up" on him/her and assume that they are weak and helpless or hostile and selfish. If possible, it must be impressed upon the child that a reduction in authority does not mean a reduction in love from his/her parents. The more alive the reality of the child returning to live with his/her parents, the more hopeful is the process of treatment.

Mayer (1972) feels that it is ultimately important that a child understand that he has come from a family and will return to it, bridging the past and future. He finds it impossible to treat younger children in an institution unless they feel that their future includes returning home. Where a child has no home to return to, it is virtually impossible to succeed in treatment. In these types of cases, Mayer concurs with Halpern (1976) in claiming that all indigenous community supports available must be convened to aid in the child's treatment. With some children it is necessary to discuss future placement as soon as treatment permits.

A child who is left in an institution with no hope for release to a community may easily become institutionalized. Absence of meaningful inter-personal relationships does not

further the development of the personality. Bettelheim (1972) argues that institutionalization does not occur only to those children who have lived in institutions for prolonged periods of time. He argues that it also affects children who have been exposed to a succession of foster homes or to disorganized family settings.

Children such as these live emotionally isolated from adults and the growth of the personality will be inhibited if the significant areas of the normal child-adult relationship are not maintained. The child is prevented from integrating his personality either in inter-personal relationships or in the community.

Barnes (1972) outlines the tremendous importance of the child-parent relationship in the process of the child's development. He feels that if there is no defined and enduring parent figure present in the child's life in relation to which the child can first develop and then resolve his feelings, he will either fail to develop the capacity for attachments, develop fragmentary ones or evolve fantasy ones. Barnes maintains that where there are no consistent and enduring parent figures, treatment is difficult and maybe impossible. The two most important elements are considered to be endurance through time and common experiences, both positive and negative.

It is all too common practice to refer a child to a residential setting with little consideration being given to

the parent-child interaction. It is the conscious or unconscious assumption that the community is getting rid of the "bad" child until residential treatment has made him "good". Blaming the victim of the combined ills of the family and the community further isolates him from the solution and further reduces his chances of successfully returning home.

According to Mandelbaum (1972), the child who finally is referred to a residential treatment centre is not likely to have had a positive nurturing experience which is essential to the development of identity and basic trust. His/her world has been chaotic, inconsistent, uncertain. The family may have broken down as a result of events happening to the parents, i.e. separation, divorce, death, physical or emotional illness, or imprisonment. The child himself may have added to the stress which caused the family to breakdown by acts of delinquency, emotional illness, severe retardation and/or behavior so intense that the family can no longer endure its impact.

The disturbed child is characterized as infantile, demanding primitive gratifications. Sometimes exploding into a rage of aggression when needs are frustrated, the child's world is filled with glaring hatred, disorganized behavior, bizarre symptoms and distorted realities.

Mandelbaum feels that residential treatment can arrange life sensibly for those children whose lives have not been

sensible and help them to understand their past in order not to repeat the pattern in the future. Characteristic in their resistance to placement, parents prefer to avoid understanding the child's difficulties that exist in their relationship with him. To understand the child and their problems with him/her is to understand themselves, and many wish to avoid this pain.

It has been stated that the child has a greater chance of succeeding if there is some degree of involvement from the community to which he will return. During the process of treatment, it is necessary to engender some hope that the child has a place to return to upon release. The child's resources in the community must receive on going support and encouragement if treatment is to be successful and one of the methods of involving parents and family in a therapeutic setting is "family therapy".

It is often difficult to involve the parents and families of children in residential treatment for various reasons. The families themselves may live in distant communities, the children may be wards of the court, the children may have lived in foster homes and/or their parents are resisting any involvement. Nevertheless, it is felt that if the parents and/or some configuration of family can be drawn into the treatment process, there is a greater chance of success with the child.

Family Therapy

Traditionally, therapists have focused on the individual person as the primary site of health or disturbance. It became difficult for them to think about relationships as other than mere reflections of intra-personal concerns. Family therapy on the other hand, is centered on the family system and the changes that could be made on that system. The family is seen as the patient and the family's interaction is more of a symptom of a malfunctioning system.

It is to be noted the family therapy focuses not on the kind of intervention, but on the source of the pathology. Any approach which perceives the system or interaction within the system as pathological can be called family therapy. The crucial aspect is the philosophy of the therapist who analyses the family situation.

Each individual in the family is perceived as having a "role" in the system which is more or less a related set of expectations. When one of the roles is not performed as expected by one or more of the family members, at least one other member is affected. The members of the family are therefore interdependent parts of the whole. Minuchin (1974) defines the family of origin as the primary source of self. He states that the self is primarily the result of the countless interactions between an individual and his significant others. Particularly in the formative years,

Minuchin feels that the development of a person's self concept is highly connected to the manner in which family members related to him or her.

The family, like the individual, cannot exist in isolation from other physical and social systems. It is vitally connected to its neighborhood and community. The family must, therefore, find ways to maintain its boundaries and yet remain open to meaningful exchange with the community. The family has a tendency to maintain balance, a phenomenon which is referred to as homeostasis. Within this concept, the family devotes considerable energy to maintaining order and stability.

Don Jackson (1957) developed this concept extensively. Satir (1967) summarized Jackson's thoughts:

- a) according to the concept of family homeostasis, the family acts to achieve a balance in relationships;
- b) members help to maintain this balance overtly and covertly;
- c) the family's repetitious, circular and predictable communication patterns reveal this balance;
- d) when the family homeostasis is precarious, members exert much effort to maintain it.

The more severe the disturbance, the more rigid and unwavering the family patterns appear to be. Stability combined with flexibility appears to constitute the healthy range of family behavior. If the family is able to provide some order at the same time as demonstrating an ability to adapt to the inevitable changes that occur in the life of

the family, it is deemed more likely to succeed as a unified force.

It is felt that structure is needed to accomplish a balance between order and change. Structure, that is, where the sub-system boundaries are clear, rather than disengaged or enmeshed. As the works of Bowen, Minuchin, Wynne and Lidz indicate, the clearness of boundaries is especially crucial in the husband-wife sub-system. If the husband-wife sub-system is unclear, then the family structure becomes subject to the development of interlocking triangles between generations. When the relationship between the parents gets uncomfortable one of the parents involves the child in order to try and re-establish a balance. This process of triangulation must change if the family system is to change. This impedes a child's ability to develop a meaningful self identity. To these theorists, it is indicative that clear communication patterns are necessary.

There are four different approaches taken by different family therapists:

- 1) Conjoint Family therapy - refers to that situation in which a therapist meets with a family and attempts to focus on the patterns of interaction in the family. The major focus is on the family pathology.
- 2) Multiple Impact Therapy - refers to an approach in which several members of a team work with individual members and various familial combinations for an intensive period.

- 3) Network therapy - expands therapy from the nuclear family to concerned others, including neighbors, friends and significant others. The aim of network therapy is "retribilization", i.e. creating a viable social network for the person or family in distress.
- 4) Multiple Family Therapy - refers to an approach where a number of families are seen at the same time. The use of other families tends to overcome some of the distance between the therapist and clients.

It is not the number of members present that constitutes family therapy, rather it is the conception of the therapist. The therapist in this setting focuses not on the kind of intervention made, but on the focus of pathology. Any approach in which the therapist sees pathology as residing in the system or interaction between members of the system can be called Family Therapy.

As previously discussed, the role of parents in the treatment of children's emotional disorders has changed and increased over the years. As early as 1909, Freud dealt with a child through his father, although his orientation was to work with the individual rather than the family.

Historically, social scientists and anthropologists have had an effect by introducing the notion that the family has had an effect on the development of the personality, in particular the work of Margaret Mead.

Foley (1974) outlines briefly the historical development of Family Therapy indicating that both Harry Stack Sullivan and Alfred Adler were instrumental in the

early development of the concept that the interpersonal and social context of an individual's development were of extreme importance. He attributes the development of the concepts of Family Therapy to the work done in the 1950's by a group of individuals working individually with schizophrenics and their families. Concepts central among family therapists were developed during this decade in the work of Laing, Bateson, Haley, Weakland, Wynne, Bowen, Jackson and Lidz. Through their work, the notion was developed that a definite relationship between schizophrenia and the family system existed.

A new language developed to explain the theories used to explain the family processes of families in distress. Terms such as pseudomutuality, double bind, schism and skew and mystification were introduced to explain the pathology in the family system. Similarities were noted between the families of individuals with schizophrenia and so-called normal families.

The most important concept developed by the family therapists is that labeled as "general systems theory". As an approach to a problem it focuses on the relationship of the person and his family system. This is seen as critical in an understanding of the pathology. Von Bertalanffy, a biologist, sought to develop a scientific basis for the theories related to family therapy. His view became a paradigm or a model for assessing family pathology.

Von Bertalanffy (1968) maintained that there were two systems in operation: an open system and a closed system. The open system, which he alleges is found in the family, is characterized by a continuous flow of component material; the closed system is characterized by the lack of movement. Further, the three properties which Von Bertalanffy attributes to an open system and which are also attributable to a family are "wholeness", "relationship" and "equifinality".

The term "wholeness" is used to characterize the interaction between the various individuals in the family system. Von Bertalanffy stated that a system is made up of interdependent parts and is not merely a sum of its parts. The family system is a result of the on going interaction between its members. From this flows the notion of "relationship" which is the study of the connections between the parts and how they interact.

"Equifinality" means, in family systems theory, that no matter where one begins to examine the system, the conclusion will be the same. Foley argues that in examining a marital relationship that it does not matter if you examine issues of sex, children, money or in-laws, the pattern of communication will be the same. He feels that if a clinician needs to understand how a couple relates to each other, he/she need only to observe how they interact with each other. The method of interacting, regardless of

content, should portray important aspects of the couple's relationship.

Von Bertalanffy described the manner in which the family system related through a process of feedback and maintained that this process was what maintained the system's functioning. He described a circular (cybernetic) model which contained both negative and positive aspects. Negative feedback was the type which corrected a system and returned it to its previous state. Clinically, the role of the "identified patient" is an example of negative feedback. For example, in the case of marital discord, the "identified patient" may "act out" in order to prevent the disintegration of the family unit. The "identified patient" becomes the scapegoat which allows the parents to unite to save and maintain the family unit. The problem no longer lies in the family relationship, but can be externalized in the child's negative behavior thereby drawing the parents together. This rapprochement serves to perpetuate the family system without ever addressing the basic issues. The parents stay together for the sake of the children and to save the family system.

On the other hand, positive feedback looks at the ways in which the system operates and uses feedback which changes the pattern of how the system works.

Families of Children in Residential Care

Bell (1975) in discussing why one should work with families of offenders, brings to light many factors which are applicable to families of children in residential treatment. He feels that youth have a social investment in their family which gives the therapist a starting point from which to work. Frequently, according to Bell, the family is the primary source of the disorder leading to anti-social behavior. Not all the explanations for delinquencies come from the family, but knowing and involving the family gives the therapist an added advantage. It was also expressed that improving the quality of family interaction can reduce pressures to behave anti-socially. Bell felt that working with the family may prevent offences in the future or lessen their seriousness. Bell takes a general systems approach in working with families of delinquents, working with the family as a whole and concentrating on the inter-personal actions rather than on the pathology of one individual. He does not subscribe to the notion that it is only the delinquent that needs to be changed, but feels that the entire family must change. This approach treats the family as one unit and does not segment it.

If a child is institutionalized in a residential treatment centre, the family is structurally segmented. The child, by virtue of his/her separation, within the institution and the family in the community. Bell concludes

that it is preferable to work with unsegmented families in the community, but maintains that it is possible to adapt the outpatient techniques to family work in institutions.

Residents of institutions come from families and will return to them. During the separation, the family in the community re-orders its life in terms of absence of one member. It then becomes difficult to re-incorporate that individual when the time comes to release him/her from the institution.

Bell feels that the individual work that an institution may undertake with a child may work against him when he comes to re-integrate himself into his family. Bell feels that some institutional programs create unintentional social and family deprivation in a child. He expressed great concern for individuals in prisons, schools for the retarded, juvenile halls and foster and group homes. He suggested that family therapy could be utilized in these settings, adapted to meet their specific situational needs. He maintains that each of these agencies or institutions is oriented essentially towards solving problems that typically have family implications and feels that family therapy provides a paradigm for their work in strengthening the family system.

Summary

The review of literature confirms the necessity of viewing a child's "disorders" within the context of his/her family. If a child from a residential treatment centre is to successfully return to his family. The family must also be involved in the process of change. It is also incumbent upon the institution to adopt a policy which involves parents/community supports as part of the change process. This appears to greatly enhance a child's potential to succeed when returned to the community from residential treatment.

The Location

Early Beginnings

Knowles Centre Inc., as it is now known, had its beginnings in 1907. A clerk with The Canadian Pacific Railway (CPR), Wilfred A. Knowles, found a cold, hungry and homeless boy one cold evening. He brought him home to his boarding house on Hargrave and gave him food and shelter.

Mr. Knowles continued to provide similar services to other children of similar misfortune. Finally, he relinquished his position with the CPR and began what was to be his life work.

Knowles School For Boys was incorporated on November 15, 1907, serving four children from its location at 738 Broadway Avenue in Winnipeg. The home moved several times as increased demands continually required larger accommodations. By 1911, Knowles Home For Boys was serving approximately 40 children and the Board of Directors acquired a 40 acre site in North Kildonan on the Henderson Highway. In 1912, Mr. Knowles, who had become Superintendent of Knowles, moved his own home and his 40 boys to the present site of Knowles Centre Inc.

In 1913 an educational program was introduced. The boys spent half the day in school and the other half doing farm and garden chores on the 40 acre site.

Superintendent Knowles retired in 1914 and the centre

carries his name as a memorial to his work. For many years, the home continued upon the pattern devised by its founder. The boys received schooling and manual training, were placed in jobs or taught the rudiments of good housekeeping and civil behavior.

A Change in Direction

In 1922 the centre developed a relationship to the Community Chest. In its early years, Knowles was a home for boys who needed a home. Generally, but not always, the boys were orphans. In some cases, the cost of care was paid entirely or partially by the families of the boys. In other cases, the care was provided by charitable assistance.

After 1922, until comparatively recently, the cost of care has been paid by the Community Chest (United Way). In 1924, the name of the home was changed to "Knowles School For Boys". This change was made to reflect the Changing Focus which would make Knowles more than just a home.

In 1945, with the advent of the foster home program in child welfare, the school changed its function and began to provide some treatment for boys experiencing difficulties with the law. From 1945 to the early 1960's, Knowles Centre provided residential care for these children as well as those who could not be placed in foster or group homes.

A fire in 1959 destroyed all but one building, and all the present buildings have been built subsequently.

Throughout its history, Knowles Centre has received support from the community. As previously mentioned, The Community Chest, The United Way, The Winnipeg Foundation and many other organizations and individuals have contributed to the growth of Knowles Inc. The Government of Manitoba presently provides a grant, but the Centre still requires financial help from time to time for various capital improvements and extensions of its services and programs.

A Therapeutic Milieu

In 1979 the name of the school was changed to Knowles Centre Inc. This change was made to reflect a change in program. The centre was now designed to provide treatment for boys who were suffering emotional and behavioral disturbances. The Board of Directors also envisioned the program becoming co-educational in nature and wished the name to reflect this.

At present (1985), Knowles Centre provides treatment to 30 children, varying in ages from 10 to 16. These children are referred through the child welfare system. Direct treatment and educational programming are provided for each child as part of the Knowles program.

The children live in sleeping units designed for ten (10), and their day to day living experiences are considered and designed as part of the overall program. This "milieu therapy" concept is the basic foundation upon which Knowles

Centre exists. Individual, group and family therapy are also major components of the Knowles program. Community involvement is also seen as a necessary component of the therapeutic milieu. This is seen as necessary in order to promote the appropriate skills which would allow the children to function in their respective communities.

Knowles Centre Inc. has also developed a summer program which is run at the Knowles Big Whiteshell Camp. This program is another facility for emotionally disturbed children to further develop necessary social and living skills.

Post Practicum

The situation previously described existed at the time the practicum was conducted (1979-1980). Since that time, the Manitoba Government has requested that Knowles Centre develop a service delivery model and staffing requirements to meet the needs of emotionally disturbed children in Manitoba. Their mandate included a review of location and facilities to provide the proposed treatment.

In October 1981, a Building Committee was established to begin the implementation of structural changes to Knowles Centre. At the same time, the co-educational program was put into place and the proposed changes in program were carried out to reflect its mandate as a provincial treatment centre.

The Closed Unit

One of the cottages at Knowles School was designated as "closed". This meant that the doors were locked and the movement of the children was monitored. The unit contained a self enclosed classroom which provided for the special educational requirements of the residents. The children ate in the unit, as did those in other units. They gradually were allowed to be more involved in activities with children in other units and the ideal was to progress to another unit to live.

My involvement was with the children and staff of the closed unit. These children were either new to Knowles School and/or had severe behavior problems that had to be addressed prior to their progression to a more open environment.

The Approach

Don McClintock, the Director of Knowles School for Boys, played an instrumental, directive and supportive role in the developing and supervising my work at Knowles. In our discussions regarding the practicum, it was felt that the goal was to maximize my exposure to direct clinical involvement with boys and their families.

As I had no previous experience working directly with clients, I initially observed as many sessions as possible conducted by the head of the "Closed Unit". Dale Torrie MSW

had headed the Closed Unit for several years and was experienced in working with these clients and their families.

I was placed in the Closed Unit and, as previously stated, began to observe therapeutic sessions with individual boys and their families. At the outset, it was agreed that I would assume responsibility for three boys and their families. This would entail seeing the boys on a weekly basis as well as meeting with them and their families.

Each session was recorded either by process recording, and/or video or audio tape. The Director of Knowles School met with me once a week to discuss my recording of the sessions as well as to discuss therapeutic interventions for the following sessions.

The same type of strategy sessions were held with the staff of the Closed Unit, which included the Social Worker, the head of the Unit, the teacher and the appropriate child care worker. Heading the child's treatment team, I was also responsible for recording the child's progression on the daily log book and relate to the staff of the Unit as a regular staff person.

When a problem of sexuality arose in the unit, I led a group of three boys in an attempt to deal with their own personal issues surrounding that problem. The group met for a short time and while not a central part of my practicum,

it was an additional therapeutic experience which was useful in my understanding of one of my three boys and of the problems of institutionalization.

In total, I spent 500 clinical hours at Knowles School for Boys during the period between October 1979 and April 1980.

The Boys

Darryl

Darryl comes from a re-constituted family. His mother, Jane, was previously married to, and divorced from, George, Darryl's father (see diagram). Jane and George had four children during their marriage. The eldest, Dick, 16, was living in a group home, because of his abusive and delinquent behavior.

Darryl, 13, the second child and the identified patient resided at Knowles School, having previously lived with his mother.

Dane, 12, the youngest boy, resided with his father and paternal grandmother.

The fourth child, then 5, was an unplanned and unwanted pregnancy and was given up for adoption at birth.

Although Darryl had resided with his mother prior to admission to Knowles, he had also resided with his father. He continued to visit there and was especially close to his paternal grandmother.

Prior to Darryl's institutionalization, he moved at will between the two households. As the parents both had joint custody, and the child moved at will between their households, this compounded the problem of truancy from school.

Jane lived commonlaw with Don for 5 years before

marrying him; they had been married legally for three years when Darryl was admitted to Knowles. Don worked as a forklift operator was basically a very concrete and seemingly rigid person. He had ambiguous feelings about Darryl and admitted that he would prefer to have his "own" children. This desire created a problem in that Jane had a tubal ligation and was unable to have more children.

Jane also did not appear to want more children. In fact, she was most reluctant to mother the children she already had. She had decided that she no longer wanted anything to do with Dick, because she claimed he was abusive towards her. Dane, she rarely saw because he was closely allied to his father and paternal grandmother.

The only child which she appeared to want a relationship with was Darryl, and this seemed to be on her own terms. Jane worked full-time as a furniture refinisher and upholsterer. She also kept herself very busy holding down two other part-time jobs selling cosmetics and jewelry. These activities, combined with her and Don's membership in a "Van Club", kept her so busy that she was unable to monitor Darryl's activities and/or behavior.

Darryl was truant from school and this truancy continued even though he had been removed from the public school system three and a half years before. He had attended two previous special schools; St. Joseph's and Marymound, but his acting out behavior had increased.

Admission to Knowles

Darryl was 13 when he was admitted to Knowles School. He was immediately placed in Unit 3, the Closed Unit, because he had a history of truancy and it was feared that he would run away.

When Darryl first came to Knowles, he had difficulty in verbalizing his feelings. This was especially true when he was upset as he was totally unable to articulate what was bothering him. He could not settle down physically, he was always fidgeting and moving around. He usually giggled in response to any comment made by an adult, especially when he was being confronted about a particular situation. Darryl's self image was almost non-existent and his only demonstrated interest was in reptiles and insects. At times, his behavior was displayed as that of a snake as he imitated their behavior and slithered along the floor, untying people's shoes.

Darryl had extreme difficulty in relating to his peers as well as adults. He preferred to be a "loner" and had virtually no friends other than his amphibian collection. He had no interest in school, either in attending and/or in any of the subject matter. He did however have some artistic talents as well as a "sense of humor".

The goals established for Darryl included a reduction in his acting out and improvement in performance of cottage

routines. Prime importance was given to Darryl's ability to form trusting relationships with adults and with his peers. The treatment plan established to meet these goals was as follows:

- 1) To provide an atmosphere in the unit and in community programs which was conducive to establishing trust between Darryl and adult staff;
- 2) to allow, within controlled limits, Darryl's acting out so that we would better understand his feelings anxieties and how they could best be worked with;
- 3) to assist Darryl in establishing a positive peer group experience where he might share with other boys the sorts of things that they enjoy and, where Darryl could share with the boys in the unit his knowledge and experience of insects and reptiles;
- 4) to assist Darryl in assuming personal responsibility through expectations of behavior; this should be done initially through personal hygiene, preparing his own breakfast and caring for his own clothes;
- 5) to provide a learning atmosphere in the school that would help overcome Darryl's negative feelings about the educational system;
- 6) to maintain family contact in visiting.

The goals set forth dealt with issues pertaining to Darryl's family, his relationships with adults and peers and his problems with school. Reaching these goals required the concentrated efforts of many people, including Darryl, his parents, the teacher and child care staff of the unit. During the period of June 1979 to March 28, 1980, changes were made by Darryl and his family which allowed him to return home and leave an institutionalized setting.

In developing a relationship with Darryl, I pursued an interest in the activities which Darryl enjoyed the most, i.e. art and reptiles. We spent time in the pottery studio where he worked with clay. As well, he shared many drawings with me which depicted his feelings about himself and his family. In depicting his family, Darryl's mother was always "out of the picture". He himself was depicted as "a pain in the vein" in a drawing which saw him as an irritant stuck in a small vein.  A devastating self portrait of a boy who saw himself as a small, meaningless obstruction to his family. In fact this "meaningless obstruction" was very meaningful in the sense that, as the identified patient, Darryl kept the remaining vestiges of his family together, involved with his "problems".

Darryl's self confidence was negligible and this determined very much how he would relate to his peers. Preferring to be aloof, he initially refused to involve himself in any games/interaction with the other boys.

As time progressed and Darryl received more and more recognition about his art work, he began to develop more self confidence. His artwork was a tool which allowed him to express his feelings as well as gain recognition from both peers and adults.

The teacher in the Knowles School emphasized his artistic abilities in various subjects. By helping her develop teaching materials, Darryl was able to display his

work in a "formal" way and on a credible stage.

His keen interest in science was also encouraged and he excelled in these areas. Darryl's greatest difficulty was in expressing himself verbally and with the written word. Although he demonstrated creativity in his thoughts, he could not express these in complete written forms, especially where any length or depth was required.

His relationships with his peers and adults grew. He seemed to have developed basic trusting relationships with a few, and this enabled him to feel more comfortable playing with his peers. Darryl's progress at Knowles increased dramatically when it became clear that he was not working alone towards the goal of returning home.

The Family

When Darryl first came to Knowles, a contract was made with Darryl's mother and stepfather to meet as a family once a week. Initially, this did not work out in practice. Because it was summer when Darryl was first admitted, there were many "excuses" for no meetings. It was not until November that the family began to meet regularly and this occurred after much overt and covert resistance.

Initially, the major work with the family centered on developing their commitment to the process of family meetings. Dad had to work nights and mom had her costume and jewelry "parties" to attend. Darryl and family meetings

were always placed second in order of importance. As part of dealing with this issue, we struggled with issues pertaining to time and personal priorities, life-style, trust and satisfying each others' needs.

As the family truly began to meet together, I witnessed a change in Darryl's abilities to communicate as well as the parents' ability to respond. Eventually, the definition of family only included mom, stepfather and Darryl. The relationships outside of this were never really clarified or dealt with.

I sensed, through the process of family meetings, a growing commitment from Jane, Don and Darryl to act as a cohesive family unit. When they logged their time "spent together", they realized that in actual fact they spent hardly any "real time" together. We set goals for interaction and some planned sharing. This helped to increase their sense of commitment to each other. Don and Jane realized that they had to incorporate Darryl and his needs into their life, while Darryl himself realized it was necessary to articulate his needs if they are to be met.

A major "triumph" occurred when a compromise was met to change the night of family meetings. Darryl, who was becoming more active with his peers, missed attending his group "program activity night", because it conflicted with his family meetings. He was able to bring the issue up at a family meeting where it was discussed. His mother agreed to

change the night of her "parties" to allow Darryl's involvement in activities with his peers. Darryl articulated his needs in a reasonable fashion, demonstrating his needs and opening himself up to being hurt. His parents responded, making compromises which they hitherto were unable to make.

Following this development, a transition program was established which would escalate Darryl's return home. He was to be transferred from a "closed" to an "open" cottage and be placed in the Knowles classroom at Munroe School. Knowles School had established a classroom at Munroe School, a few blocks away. This enabled boys nearing a return to their own homes, an opportunity to attend a community school. They were, however, all housed in one classroom which contained all grades. This gradually gave them some exposure to the children and programs in the community.

Gradually, Darryl was to spend more and more time at his parents' home and family meetings continued. In fact, the family meetings began to be held at Jane and Don's house. Near the end, The Children's Aid Society (CAS) worker responsible for Darryl began to attend as well, so that he would gradually be worked into the family. This was an aim to build supports for the family on an on going basis, as it was felt that problems might occur when Darryl actually returned home.

While living in the open cottage, Darryl assumed greater responsibility for his personal conduct and care. He was allowed greater community involvement and given greater responsibility for his own comings and goings.

Darryl's progress at Munroe School was monitored carefully and it was determined that he should continue at Munroe to finish that school year. He would transfer to a school near his home in the up coming fall if he successfully finished his year at Munroe.

The family came a long way in helping Darryl to grow and develop. They themselves made drastic changes in their own growth and development as individuals and as a family unit.

Don and Jane began to resolve one of their major conflicts which had a definite and deleterious affect on Darryl. The fact that Jane had a tubal ligation and was unable to have more children drastically affected Don's ability to realize his dream of having his "own" children. Once clearly aired, Don began to view his relationship with Darryl truly from a parental perspective and this option could be further explored.

Further, a final resolution and dismissal of Darryl's natural father's role allowed Don and Darryl to explore a parent/child relationship.

Jane, who at best was still ambiguous about being a mother, still was able to make some compromises in her life

to involve Darryl in a meaningful manner. She herself had many ways to avoid the responsibility of parenting, but was able to redefine her role in a more positive way. She incorporated Darryl into some of her activities and, more importantly, took some time to listen to his needs.

Although problems still remained, the fact that the family unit was able to rally around Darryl and develop a more cohesive relationship, ensured his return to the community. Above all, the fact that he was wanted and that this was followed by actions, made a major difference in Darryl's ability to gain self confidence and develop more trusting relationships with peers and adults.

In retrospect there was some hope for Darryl's successful re-integration into the community. His family had made substantive changes in their behavior in order to accomodate his return. There is no doubt that some of these changes could be eroded over time, but community supports were put into place which would hopefully help the family to maintain and continue to grow.

David

David was a 13 year old native boy who was abandoned at birth by his mother, Corry. Until he was 4 years of age, he was cared for by his maternal grandparents. At the time of his grandfather's death, his Aunt Ethel was granted legal custody. The extended family had all resided together on a farm in northern Manitoba until that time, but following the death of the grandfather, the family moved to Winnipeg.

When she moved to Winnipeg, Aunt Ethel became involved in a commonlaw relationship which lasted, without serious crises, for three years. At that time, the union dissolved and David was taken into care for eight months by the Children's Aid Society of Winnipeg (CAS). After the eight month period, the relationship resumed and David returned to live with his Aunt. Subsequently, a boy named Johnny was born to Ethel and the relationship terminated when her husband deserted the family.

Prior to coming to Winnipeg, and following that move, the family always depended on welfare for an income. The family was illiterate and had no marketable skills.

Since David was 4 years old, his Aunt Ethel played the role of mother to him. It was she who he identified as his mother, although he was aware that Corry was his "natural" mother. He called them both "mom", which was often confusing, although in his mind Aunt Ethel was his mother. For our purposes, Ethel will be referred to as mother and

Corry as the natural mother.

The relationship between David and his mother was warm and caring, although it was obvious from the outset that she was unable to place any limits upon his behavior. As a result, David had a history of delinquencies and, by the age of 13, had been held at the Manitoba Youth Centre (MYC) a total of eleven times. His most recent charges were for a series of Break and Enters, which were dropped by the Court as David did not appear capable of understanding the nature of his offences.

For the past several years, David had constantly run away from home and from ultimate placements, such as receiving home settings. He admitted to a lengthy sniffing history that had been occurring on a daily basis for several years. David cannot could not remember, and we were unable to determine what types of solvents he was sniffing. He has indicated that he had sniffed glue and plastic wood.

David appeared unable to integrate even the simplest messages and experienced difficulty in any change of established routine. If David was told that something was going to occur at some point during one day and was then told that it was not possible for this to happen, he did not integrate the second message, but continually pressed and asked when the event is going to take place.

David also displayed considerable difficulty in separating the present from the past. He spoke of a father

in the present tense only to later announce his father had been dead for ten years. Except for a short period in David's life when Ethel was living commonlaw, there has been no significant male figure present and David never knew his natural father. He appeared to live with the fantasy that he had a father.

David also displayed a totally flat affect around any situation that should raise emotional consciousness. When he did display a show of emotion, either through anger or crying, the duration of the emotion was extremely short, i.e. approximately 15 to 30 seconds. Immediately following the outburst, he moves off and becomes involved in some activity as though nothing had occurred. Although these outbursts were ineffective in terms of going to the root of the problem, they offered an outlet to David. They seemed to allow him the opportunity to "let off steam" and thereby go on.

When David was admitted to Knowles School, he was again a temporary ward of CAS Winnipeg. His mother accompanied him to the pre-admission meeting where she expressed deep concerns. She did not understand his dislike of school and stated that he showed disrespect for her wishes and authority. She felt intimidated by him and despaired that she could do nothing to either help him or prevent him from further getting into trouble.

Despite the large amount of instability, there still

appeared to be a great deal of caring between David and his mother. Seemingly well intentioned, Ethel was unable to carry through with her commitments. Consciously or unconsciously there were contradictions between her words and her actions. She expressed the desire "to help" but was never actually available to be involved in the process.

Despite having committed herself to weekly family meetings, Ethel was not to return to Knowles for several months. The list of excuses was endless: no taxi fare/bus fare, took the wrong bus, forgot, et cetera. Attempts were made to give her vouchers for the bus, go pick her up for the meeting and/or hold the family meeting at her home.

Attempts to involve Corry, David's natural mother, were made as well, but to no avail. The most reliable and hopeful person in David's life ended up being his Aunt Pat, another relative who offered assistance and who seemed more reliable. At the end of my practicum there was some hope that she might continue involvement with David.

As attempts were made very unsuccessfully to involve and redefine David's family, the main focus of David's treatment program was at Knowles.

The plan was as follows:

- 1) David should be exposed to secure limits and structure within which affection, caring and reassurance is provided;
- 2) support should be given to help David understand and change his pattern of running away;

- 3) David should be aided in developing positive relationships with peers and adults, especially with one key worker to help alter the pattern of abandonment in his life and;
- 4) an inter agency contact with CAS should be made to commence integration of David into a new foster family.

The first three months of David's stay at Knowles saw him "settle in" to one cottage. Every week he was disappointed when his mother did not attend family meetings. Ethel and Corry both expressed verbal desire to attend family meetings, but in actual fact, never followed through. They were unwilling or unable to involve themselves, yet they did not wish to sever their relationship totally, thereby admitting to no involvement. CAS arranged a meeting with Ethel and Corry to establish who in fact would be responsible for David and to clarify their commitment to him. That meeting never transpired and by default plans were undertaken to take David into permanent care and a new focus was given to his eventual discharge to a foster family.

David's staff and peer relationships were extremely superficial, although he himself was constantly seeking affection and attention. At times he could not remember the names of people around him and it was obvious that he could not establish any real relationships with anyone, staff or peers.

David's ability to retain significant information was

questionable. He was unable to remember his age, his birth date and could not describe significant events that occurred in his life, even if they were only several days old.

The boy was also very much of a follower and did not appear to have a mind of his own when with his peers. It was found that in play he did not have the ability to fantasize and that his play was basically at a primitive level.

In order to better understand his behavior and to develop a more comprehensive treatment plan, it was decided to refer him for psychiatric/psychological and neurological testing at the Health Science Centre (HSC). When I terminated with David, this examination had not yet occurred and his behavior remained virtually the same, although he was more comfortable residing at Knowles.

David's return to his family did not seem likely to ever occur. The only hope he might have had was to completely reconstitute his family. He was to be taken into the permanent custody of CAS Winnipeg and placed in a foster home. The success of his integration into a new family would depend greatly on the foster family's commitment to him. It would also depend on his willingness and ability to transfer his family allegiances. Despite of continual rejection by his family, David continued to be stoically committed to them. The long term prognosis for David's

successful return to the community with meaningful family-like relationships was not very good.

Randy

Randy was the second of three children born to Glenda. Randy, 9, and his older sister Anna, 13, had the same father, while their younger sister Amanda, 2, was the result of their mother's marriage to Jeff.

Glenda and Jeff had been separated for two years and Anna and Randy had just returned to live with their mother. Glenda had virtually abandoned them with Jeff when she decided to leave the marriage. She could not cope with the children and leave the marriage at the same time. Randy was not aware that Jeff was not his natural father, but Anna vaguely remembered her real father.

The family had a long history of physical abuse. The children's stepfather was a former Green Beret who controlled his wife and stepchildren by using physical force.

Since the age of one, Randy had been physically abused and beaten. This appeared to be the usual and only form of physical contact that he was accustomed to receiving from men. The beatings were the rule, rather than the exception in Jeff's relationship to Randy. The boy was beaten whether he was good or bad.

Anna received similar treatment, but to a lesser extent, i.e. she was only beaten when she had misbehaved. This abusive behavior to Anna continued and stopped abruptly at the time when Glenda left her husband and three children

in Ontario to move to Winnipeg. At this point Anna became the surrogate mother to Randy and Amanda, as well as Jeff's constant companion. There was some speculation that the relationship between Anna and Jeff was incestuous, although there was no substantive proof of that.

Both children were abruptly returned to their mother when Jeff established a commonlaw relationship with another woman. He did, however, keep custody of his natural child, two year old Amanda.

Randy at Knowles

Randy was the youngest boy at Knowles when he was admitted at the age of 9. He was placed there after attempting to burn down an apartment block because he was angry with two of his friends who lived there.

Initially, Randy's anger was so overwhelming that it occupied the majority of the attention of the cottage staff. It took at least three people to contain him from physically hurting himself or anyone else.

The first goal was to teach Randy how to recognize and control his own anger. As he sensed his anger increasing he was taught to, and became more and more capable of, withdrawing himself from the situation by going to a quiet space to collect himself.

Originally, my involvement was to be solely with Randy on an individual basis in order to give him total access to

one person who could help him to deal with his anger in a constructive fashion. We met weekly to play together and try to develop a trusting relationship.

After six weeks of family meetings with the male social worker in charge of the unit, it was felt that no progress was being made. One of the major obstructions was considered to be the fact that the social worker was a man. Both Randy's mother and sister sat submissively throughout the meetings while Randy acted out.

It had been noted after a family conference that Glenda was able to converse freely with female staff. She appeared much less intimidated by women and this was the main reason why I undertook to meet with this family. It was also felt that a female social worker could act as a role model to Glenda in parenting as well as demonstrating how to control Randy in a consistent and caring manner. It was important to demonstrate to Glenda that setting limits and controlling a child's behavior can be done in ways which were not physically violent. As well, it was very important to demonstrate that she also did not have to be passively accepting of abusive behavior.

I continued to meet with Randy on an individual basis, but my major involvement became with the family on a weekly basis.

The Family Meetings

During the initial socializing phase of the first family meeting conducted by myself, the family secret came out. Glenda inadvertently informed me that her former husband Jeff was not the natural father to Anna and Randy. This opened an absolute floodgate for Randy who had always assumed that Jeff was his father. This revelation seemed to allow Randy the freedom to hate Jeff for having abused him. It also opened a whole series of questions regarding his "real" father.

The issue of Randy's hatred for Jeff was to be the source of discussion for many family meetings. The other major focus for family meetings was to develop concrete structures which would aid both Glenda and Randy to control Randy's anger and acting out behavior on weekend visits. Weekly goals were set with expectations for weekend behavior. They included such issues as: 1) no smoking; 2) no swearing at mother; 3) sleeping in his own bed and 4) no playing with matches.

We also developed a strategy which would allow Randy to physically withdraw from his family at home. A special space in their small apartment was designated as Randy's quiet space. This seemed to make him happy as this technique was working quite well at Knowles.

It became apparent in the family meetings that Anna, 13, had always been the only one who could set some controls

on Randy. Anna was very sophisticated and mature beyond her years. At 13 she was sexually involved in a relationship with a 16 year old named Brent.

Anna had always been very close to Randy and had effectively been his mother for the last few years. She herself was experiencing a developmental crisis and, as the meetings progressed, it was obvious that she was no longer interested in playing the role of the parent child.

Anna and her mother had usually shared their experiences as would girlfriends. Glenda would allow Anna to control Randy and the family "functioned" accordingly. At this point Glenda was beginning to feel very concerned about Anna's conduct as she spent less time at home and more and more time with boyfriend Brent.

Although Glenda felt safer that Anna was only involved with one boy, she was beginning to worry how she would offer controls and guidance for her daughter.

At the same time, Anna felt very confused regarding her relationship to Randy. She was ambiguous about her role. She really didn't want to parent Randy any more; she herself was going through a developmental crisis and really required direction in her own right.

Often Anna avoided the parental role by removing herself. She spent weekends at her Aunt's and she missed family meetings. This caused Randy to be very angry as he really missed his sister. He tried to threaten her to make

her return to her old role.

As well, Randy made more threats to his mother in an attempt to have his emotional needs met. Her response was to reject him and send him right back to Knowles. She felt helpless in controlling him.

Glenda was given considerable support in parenting; as a single parent she had a double burden. She began to rely considerably on some of the techniques she had observed at family meetings. This transition began to occur as she realized that Anna could no longer be relied upon to parent and, in fact, needed parenting herself.

CAS of Winnipeg was also notified regarding Anna's situation and they were to intervene with more supports for Glenda in order to control Anna.

As my practicum at Knowles was ending, and Randy was being transferred to an open cottage, a CAS social worker and another female social worker from Knowles assumed responsibility for the family. They were planning to continue role modeling for Glenda as well as offer her support in dealing with the problems now being posed by Anna.

Randy's family was indeed very complex and his continuing stay at Knowles would continue to facilitate changes in their interaction. The amount of abuse perpetrated on all members of the family unit had been phenomenal. Randy had made great strides during his stay at

Knowles in learning to control and understand his incredible anger. His mother was only beginning to gain some control over herself and assume a parenting role. She would soon have to address the problems facing Anna, as well as continue to deal with her own and Randy's problems.

The prognosis for Randy's successful return was not very promising. The complexity of the family's problems were enormous, both as a unit and as individuals. Whether the therapeutic interventions would be enough, appropriate and/or effective is difficult to predict.

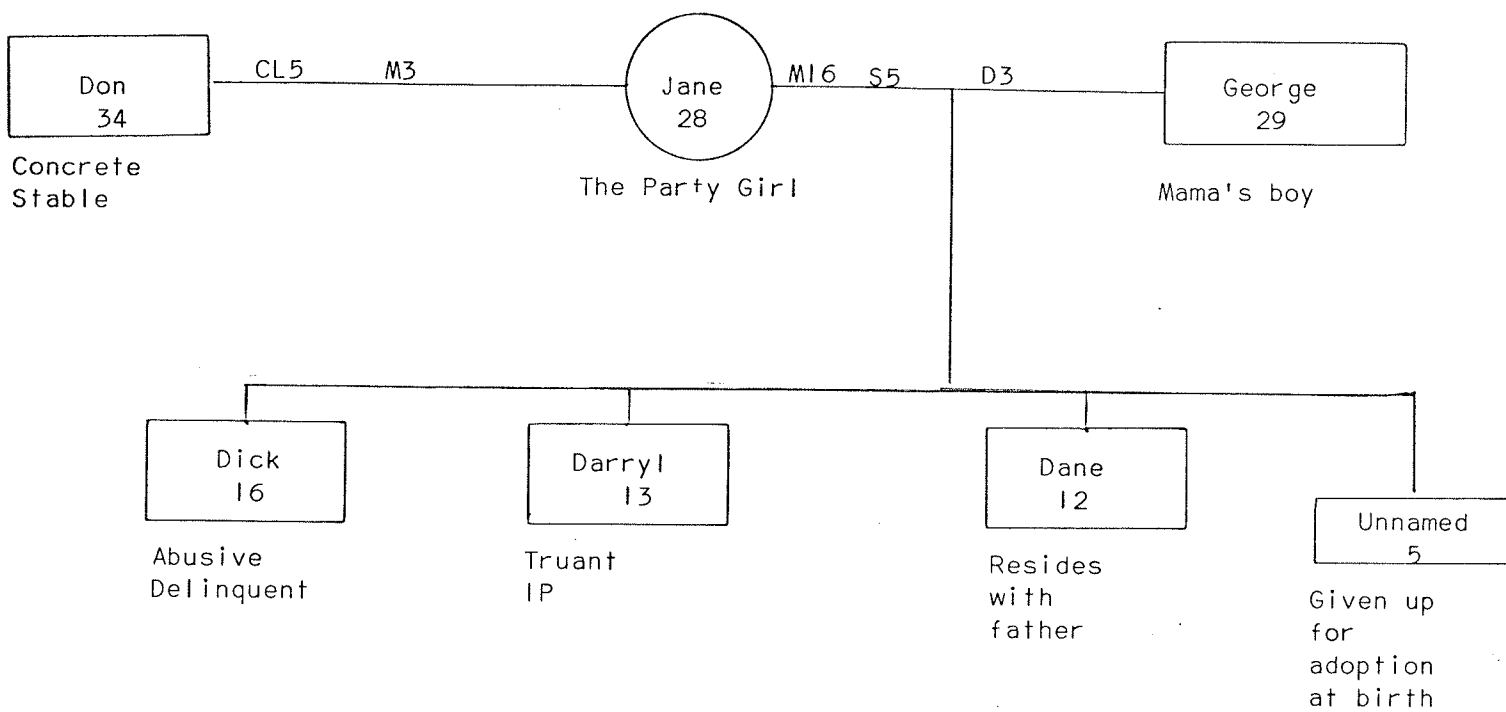


Figure 1

Darryl's family of origin

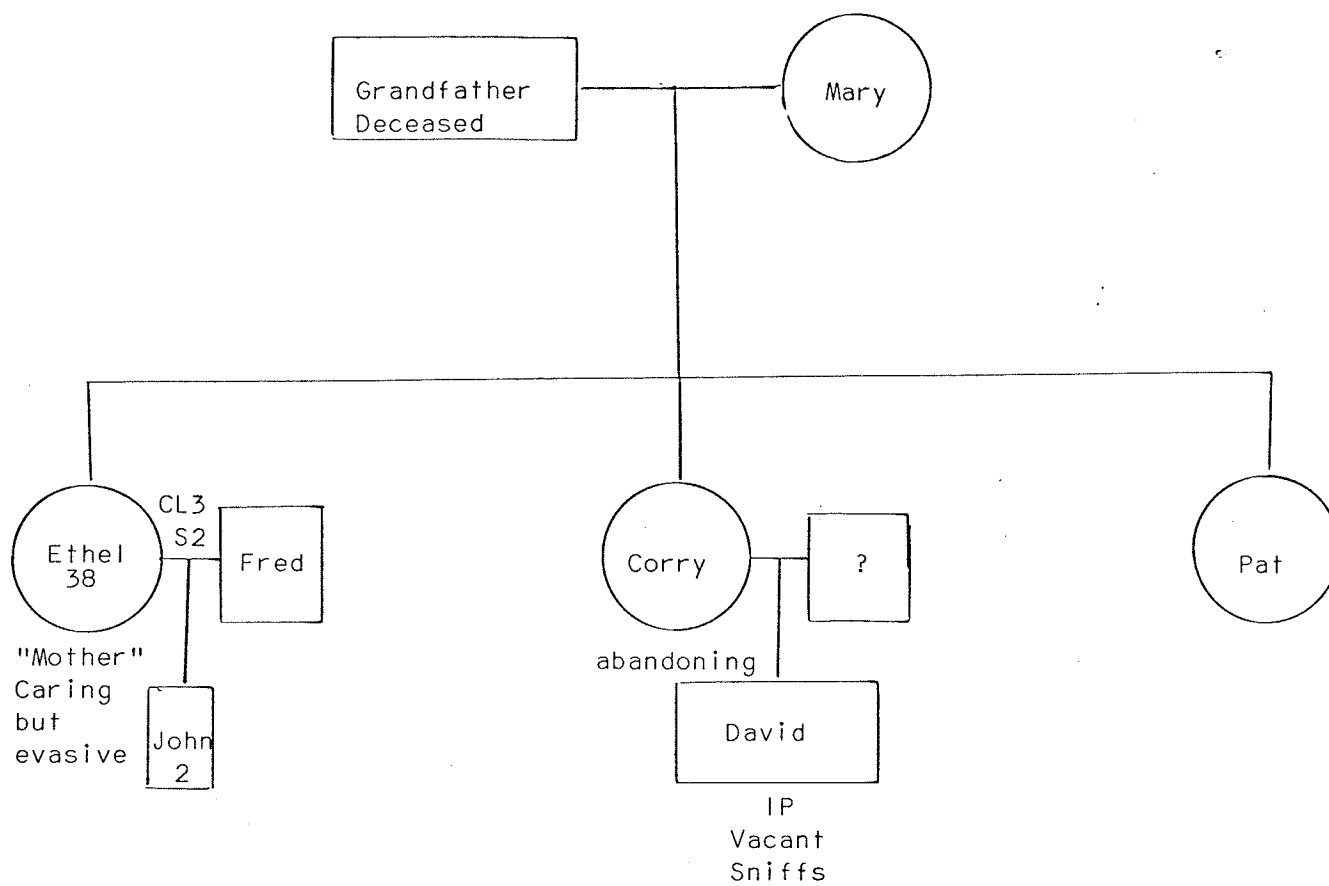


Figure 2

David's Family of origin

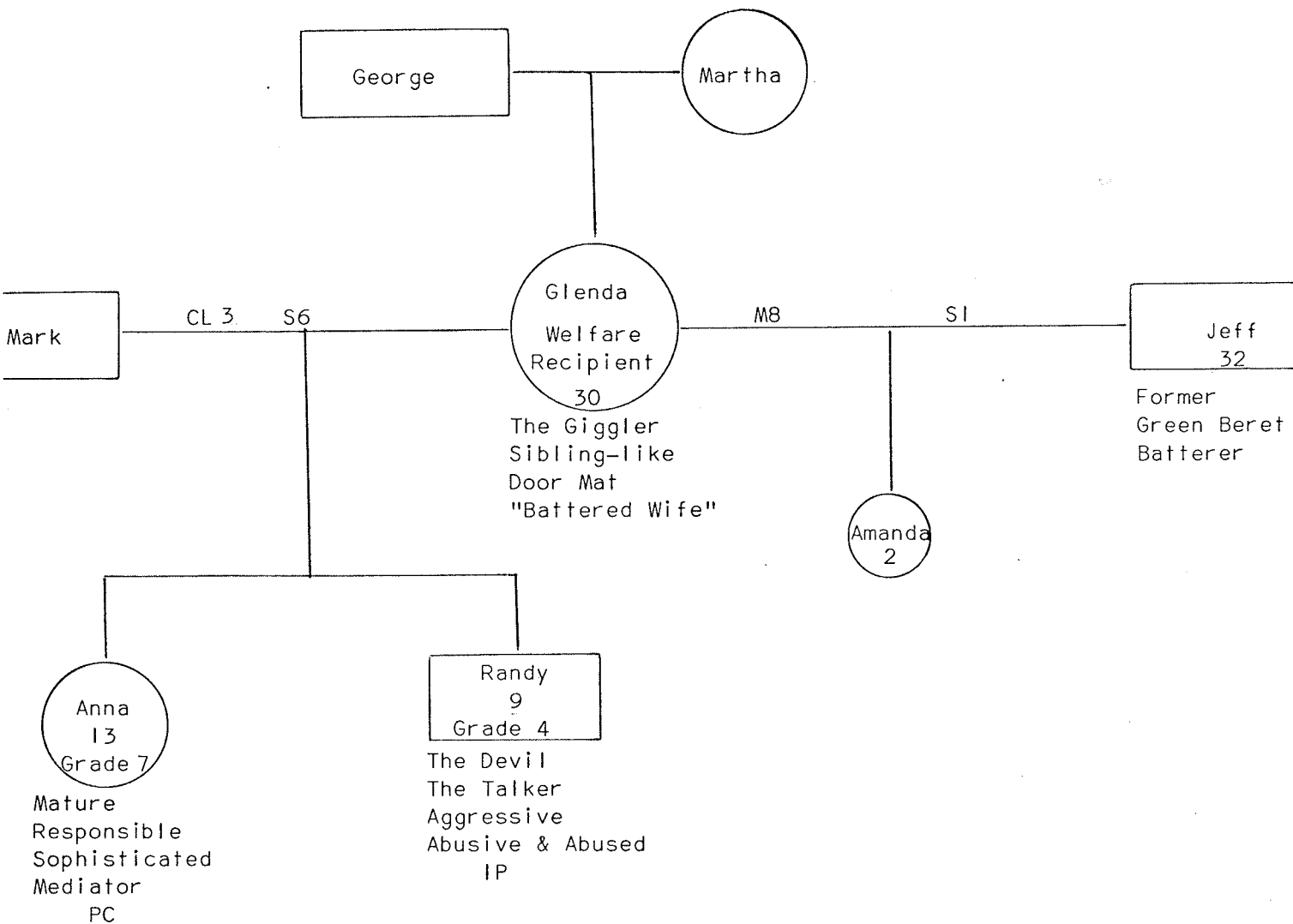


Figure 3

andy's family of origin

Conclusion

Parenting children is not an easy task and very often those who take on this task do not do so consciously and are not really prepared to take on the responsibilities. We have all been socialized to marry and have children for this role whose complexity is always understated. Socialization has worked reasonably well, on the whole, but there are no guarantees. The ever increasing pressures placed on the family by the socio-economic system are causing the family to change in structure and we, as social workers, are constantly dealing with the results of the family's societal interactions.

Minuchin (1974) describes the role of the family as the unit which "imprints its members with selfhood". In his paradigm we experience identity in two ways: 1) by experiencing a sense of belonging and, 2) by experiencing a sense of being separate. The family is the unit where the individual incorporates the sense of both these experiences and combines them, integrating them in his/her self concept.

In the early process of socialization families are more directly involved in moulding and programming a child's behavior and sense of identity. They have more control over the child's outside experiences and the child is totally dependent on them to meet all of their needs, both effective (emotional) and instrumental (physical). Creating a sense of belonging is a very important factor in the child's

development as his/her identity and need gratification is directly associated with a specific family.

At the same time the sense of separateness is being established and the child's individuation from his/her family is developed through participation in different family sub-groups, in different family contexts and with extrafamilial groups.

The final influence on an individual sense of identity comes from interactions with and belonging to other societal groupings. The family becomes the point from which the individual can leave to partake in societal interaction, a point to which he/she ideally can return to for nurturing, caring and integrating.

The family's role then is twofold, it prepares the individual to enter society in a productive capacity, productive in the technological sense as well as in the interactional one, and it nurtures and repairs those returning to it from what is not always a positive experience of society.

The family as a system is affected by many other systems, some of which are supportive while others are antagonistic. It is obvious that all of these affect the way a family can nurture and care for its members. The family itself has relinquished a considerable degree of its control over the socialization of children to other external agencies. These range from the mass media to the

educational system and they effect children at an earlier age than ever before.

The structure of the family is constantly changing, conforming to external pressure either consciously or unconsciously. These changes can be viewed partly as a developmental process and partly as an adaptive process and it is these components that a social worker must keep in mind while working with a family as a system.

In his analysis of systems, Foley (1974) quotes Edgar Levenson as saying that a system's approach "is not just another way of viewing reality, but a paradigm, a model which enables us to see a new pattern and, therefore, a new reality". The individual in the family is no longer identified as the "patient", but it is the entire family interaction which is analyzed and viewed with the aim to change. Individuals in a family unit act inter-dependently and it is not just their action but their interaction which is important if the nature of the family's pain is to change. The pattern of family interaction is circular; how each individual and sub-system relates in the system reinforces and maintains the family functioning. It is by breaking these old interactional patterns that changes in the family are made possible.

In reviewing the three families, it becomes apparent that there is a major thread which joins these three boys whose situations are drastically different. Each of the

families' problems was unique, but it is felt that without family involvement in the process of change, the boys would have less chance of succeeding when returning to the community.

Each child had an enormous emotional investment in his family and their involvement or non-involvement greatly affected the child's motivation to examine his own process. Also, as the family's interaction improved, this seemed to reduce the need for the child to act anti-socially. This was particularly noted in the case of Darryl whose behavior improved as the family began to function more effectively as a unit.

Because the boys were institutionalized and the identified patient, it was important to examine the interactions of the family, rather than concentrate on the pathology of one individual. Further, in each of these cases, it was important to note the societal position of each family to get a better understanding of the history of their interactions.

Darryl from the lower working class, David from a native welfare family, and Randy from a white welfare family; all from different backgrounds. One family was re-constituted while the other two were single parent families, these too were important factors to deal with. David's family in particular, had virtually no definition. This made it very difficult to work with as no one was prepared

to accept responsibility for a relationship with David. It was necessary in that case to be innovative in an attempt to find a family system which would work. The most reliable Aunt, Pat, seemed to be his best link, but ultimately a foster placement was necessary. Given that situation, it was deemed necessary to involve the future foster parents in family meetings prior to any release from Knowles. This would increase the chances of David succeeding if at least some type of bond were established between he and his foster parents.

While a child is institutionalized, the remaining family members re-order their lives without the missing member. When the child returns, he has changed and so has the family. This phenomenon greatly effects the child's ability to re-integrate successfully unless great care and attention is taken to involve the family at all stages of the child's detention, the pathology in the family which created the situation will, in all likelihood, re-occur.

In principle, as part of a holistic approach in dealing with the family, their total involvement is extremely important. In actual practice it is often very difficult to involve every family member. The social worker must be innovative in trying to ameliorate the family's situation and help to create a different environment for the child to return.

Economic and social issues must also be addressed if

the family is ultimately going to be successful. These issues include basic economic factors relevant to all families; such as low education, low skills, unemployment, and racial and cultural differences. All of these systems are external to the family and effect the way in which the family copes.

The Single Parent Family

A phenomenon which is becoming increasingly more prevalent is that of the single parent family. In 1976, one parent families made up 10% of all Canadian families; of these one parent families 85.5% were headed by women, 14.5% by men. This phenomenon is one which adds increased stress on the family system as a whole as well as on each of the individual family members. It throws a completely new dynamic on the family's interactions because one of the members of the parental sub-system is no longer directly involved in parenting, either in an instrumental or an effective manner. If there is some involvement it is usually in the instrumental arena through support and child maintenance payments, but the effective area is often left sadly deficient. In fact, it is often the case that the remaining parent becomes so involved in the instrumental area the he/she also avoids the effective role in parenting. The children are then left to seek a replacement for this deficiency and their search often leads them in many

directions which may be painful to themselves and their families.

The extended family can play a very important role in giving support to the single parent family, although it is important that they do not interfere with normal family functioning. The roles must be defined clearly to avoid interference as well as allowing for the closeness required to provide the needed nurturing. This type of interference often leads to intergenerational enmeshment. This type of enmeshment occurs when the single parent's roles as both parent and child are overlapping and no one understands their role.

The clarity of boundaries within a family can be used to determine how well a family is functioning. Some families turn in on themselves and create their own little world. The concern is real, but as distance between family members decreases, so does the definition of individual roles. Such a system may be overloaded and lack the resources to cope with outside stress.

The family support system need not only be defined as the family of origin, but can and does include friends who are not related. The composition of this sub-system is not that important, as whomever it may include it has the potential of operating very well if the lines of responsibility are clearly outlined, i.e. the boundaries are clearly drawn. This family support system can become very

important to the single parent family, and indeed by the very reason for its survival and success.

Parenting

Parenting is a skill which requires the ability to interact with children on several levels. One must be able to nurture children, give them direction as well as control their behavior. Depending on the child's age his/her development needs and the parent's capacity, the parent will utilize each of these components in varying degrees. It is the parents' ability to judge how and when these different roles are appropriate that makes them effective parents. Parenting itself is a very difficult process which requires skill, skill which is not learned easily and which people do not come by "naturally".

The parenting process, i.e. how parents interact with their child, is linked closely to the child's own developmental needs. A young child's primary need is that of nurturing; this is joined later by a need for guidance and control. As a child matures to adolescence, the demands made by adults often conflict with the growing child's need for autonomy. It becomes very obvious at this point that conflict is inherent in the parenting process. Parents cannot protect and guide without at the same time controlling and restricting. The manner in which these interactions are enacted and this conflict is acted out is

basic to the parent/child relationship.

It requires great skill as a parent to be able to control and guide a child through its developmental process while maintaining the family unit as a place where the child can both attach and detach its identity.

In one of the cases, that of Randy, the single parent family attempted to utilize the parental child as a method of coping.

The Parental Child

The Parental Child plays a special role in any family and has traditionally been a natural arrangement in large families and families where both parents work. The PC child plays a similarly important role in a single parent family where, as in other cases, the PC aids in caring for younger children. The caring given by the PC child can, as in the case of parents, be either on the instrumental level, effective level or both. As a result of this role, the PC develops responsibility, competence and autonomy beyond his/her years. It is a role which I feel is a very important one in the single parent family as the remaining parent cannot operate successfully by isolating him/herself in the parental sub-system. However, there are both benefits and dangers involved in this process.

By necessity, the interaction between the members of the single parent family has to change. This is a critical

aspect to recognize. The parental sub-system no longer has two people who share in the parenting process and who, in doing so, combine to make decisions which affect the children's sub-system. The remaining parent is left having to provide for all of the children's needs on an instrumental and effective level and is required to do so while guiding, nurturing and controlling children's behavior. Extra familial supports are extremely important to the parent in order to alleviate the constant pressure on that individual to provide for his/her family. These supports can come from extended family, friends and state supports such as day care, social workers, affirmative action groups, et cetera. We should not minimize the importance of these support systems as they are absolutely crucial to the single parent if he/she is not to turn for sole support to the parent child. The parent child does, however, play an important role in sharing the family's responsibilities as well as providing companionship for the single parent. The relationship between the single parent, the PC and the other children changes drastically and in its most effective operation can be very democratic in nature. The children share much more in the family's decision making and in the ordinary daily family operations in a single parent family.

However, in the single parent family it is very easy to run into difficulty if the lines of authority and

responsibility are not explicit and clearly outlined. It is too easy for the parent to abdicate his/her parenting role to the PC, leaving the child to be the main source of guidance, control and decisions for the other children as well as for him/herself. In this kind of situation the parent's own demands on the PC can conflict drastically with the needs of that child in his/her own developmental process.

Learning the Skills of Parenting

Parenting is a skill for which very few people have received formal education. There are no degrees offered in it and most individuals assume the responsibilities without understanding its complexities. The apprenticeship served in one's family of origin is expected to serve one as an example of what family life and families are all about. Yet the experiences an individual has had in his/her family of origin do not always prepare him/her for a parenting role. In fact, the reverse may be the case.

It is possible then to assume that parenting skills can be learned? Can old patterns of interaction and processes that are no longer functional be discarded and replaced by new ones? The therapeutic process is one which can provide such learning; it, in itself, is a process of learning (Dahl, 1973). Therapy quite often consists of learning things the individual could easily have learned at an

earlier time, or learning things which, because of circumstance, could not have been learned easily. If therapists are providing an opportunity for learning, not "curing" in a pathological sense, they assume the role of teachers and in the best sense that is done by being a role-model.

Therapists "treat" by offering opportunities to take in new information, or to re-organize the framework through which information is perceived and stored (Dahl, 1973). The therapist can lead the family into a new way of thinking and behaving, many new options can be opened to the family in therapy. A very effective way of accomplishing this goal is by role modeling; it involves the therapist at all levels of interaction: as the therapist, the teacher, the parent and the children. This involvement is at both the instrumental and effective levels, but the effective level is both more difficult to achieve and very crucial in modeling family interaction. The therapist is required to be caring as well as guiding and controlling in the family process; this is the role which the parent can and must learn in order to be effective.

Styles of working with people vary from person to person depending on basic beliefs and attitudes. If we believe that people are basically good we will respond to them differently than if we feel the reverse. Rather than being cautious and self protective, we will be willing to

take some risks knowing there are times when we might be exploited.

At the same time, if we believe that people want to grow and develop into creative, friendly, productive people, we are more likely to try and bring out the best in them. Furthermore, if one believes that behavior is primarily learned, rather than inherited, one views a therapeutic relationship as opportunities for people to learn new attitudes and behavior.

With these three things in mind, it is important to approach our clients in an empathic and caring fashion. Empathy, putting oneself in the other's place without losing objectivity, is of prime importance. Combined with these values is the ability to be genuine and concrete, i.e. to be honest and down to earth.

People respond more positively if the therapist demonstrates an honest caring approach. Their ability to change is ultimately in their own hands, but if the therapist demonstrates a caring attitude, they are more likely to learn from their interaction with the therapist when the therapist confronts them.

Satir's growth model is based on the premise that people's behavior changes through the process of interaction. In her model, the therapist is an integral part of the family in therapy and any action the therapist makes (touching, holding hands, asking favors, etc.) is used

to help the client grow in the context of a relationship.

Thus, the therapist uses him/herself in role modelling good relationships/interactions. Because of the therapist involvement, he/she provides an example for growth/change.

Modeling a parenting role offers the therapist the added advantage of not setting up the parent for failure in the eyes of the children or in the parent's own eyes. He/she must be mindful of not usurping the parents' role. The therapist, however, should act out for the parent the role he/she should be playing, especially in the area of feeling by demonstrating consistent caring, warmth and empathy, yet being able to confront when necessary. Whereas most parent effectiveness training programs emphasize the instrumental approach to parenting, this approach deals with the areas of the effective, i.e. the emotional aspects, without negating the instrumental areas.

Summary

In summary, when working with families all these various components must be kept in mind. The principle remains that the context should always remain within the family unit, however that unit may be defined.

In particular, when one member of the family unit has been designated as the "identified patient" and institutionalized, it is imperative to work with the family unit in order to maximize the success of his/her re-integration into the community. The amount of support and understanding available in the community directly affects an individual's ability to succeed. If family members, or the support system as defined to suit the circumstances, are dynamically involved in the process of change there is a greater chance of re-integrating the child into the family/community.

In retrospect, there was some hope for Darryl's successful re-integration into the community, less for Randy and even less for David. Darryl's family made substantive changes in their behavior in order to accommodate his return. There is no doubt that some of these changes could be eroded over time, but community supports were put into place which would hopefully help the family to maintain and continue to grow.

Randy's family was indeed very complex and his continuing stay at Knowles would continue to facilitate

changes in their interaction. The amount of abuse perpetrated on all members of the family unit had been phenomenal. Randy had made great strides during his stay at Knowles in learning to control and understand his incredible anger. His mother was only beginning to gain some control over herself and assume a parenting role. She would soon have to address the problems facing Anna, as well as continue to deal with her own and Randy's problems. It is more difficult to predict their success.

David's return to his family seemed the least likely. The only hope he might have had was to completely reconstitute his family. He was to be taken into the permanent custody of CAS Winnipeg and placed in a foster home. The success of his integration into a new family would depend greatly on the foster family's commitment to him. It would also depend on his willingness and ability to transfer his family allegiances. Despite continual rejection by his family, David continued to be stoically committed to them. Coupled with the family problems, David also faced many physical/emotional problems which were yet to be clinically assessed. The long term prognosis for David's successful return to the community with meaningful family-like relationships was not very good.

In working with these three boys and their families, it became very apparent that social workers must be flexible and creative in their interventions. Their analysis must

encompass a system's perspective recognizing all of the factors which impinge on a family/individual's social functioning.

One of the tools at their disposal is systems theory and its application through family therapy. There will be those for whom this tool does not apply, those who require a different kind of clinical intervention. It is equally important to be able to recognize the limitations in system's theory and be able to make appropriate referrals when necessary.

However, a system's approach allows the social worker to expand his/her horizons, to escape the practice of blaming the victim. it allows one to be creative and utilize as many resources as possible and as required to deal with problems which cause real pain to our client. In this case, the boys of Knowles Centre and their families went through a process which had the potential of changing some aspects of their lives, hopefully making it qualitatively better. The fact that some of the boys received some support from their families was especially crucial at a time when they were in residential care. They were not being left to "change" on their own, but were involved in a process of change with their family.

To reiterate, in order to maximize the potential success of a child's return from residential care to the community:

- 1) one must attempt to involve the best available community support system;
- 2) the therapist must, without losing objectivity, be empathic, creative, caring, honest and concrete in the process of aiding the family learn new behavior;
- 3) the therapist must confront when necessary;
- 4) the family must make a commitment to change and the change process;
- 5) the therapist is a role model in the learning process; and
- 6) the therapist must be flexible enough to explore alternatives if the family of origin refuses involvement. This must be done while the child is in residential care in order to establish an appropriate support who will be involved while the child is in care.

There are no magic formulas or panaceas, but given a skilled social worker who believes that people are intrinsically good and want to change but require support, there remains some hope. A system's approach is a useful tool, again not a panacea, but a tool which does allow families to have some control over their own change.

For children in residential care this is a very important consideration as they are already segmented from their families/society. They need to know they are not alone and that their problems are shared by others.

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