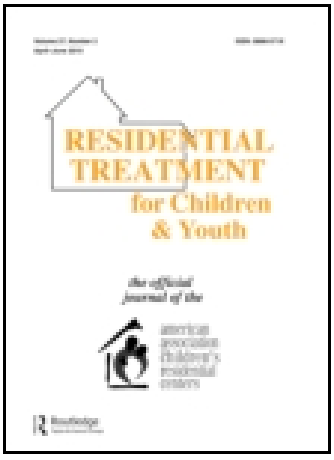

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A New Perspective on Youth Care Programs: Using Attachment Theory to Guide Interventions for Troubled Youth

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THEME ARTICLES: RELATIONSHIP AS A BASIS FOR TREATMENT PROGRAMS

A New Perspective on Youth Care Programs: Using Attachment Theory to Guide Interventions for Troubled Youth

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ABSTRACT. Traditional models of residential care for troubled youth are based on the assumption that their difficult and threatening behaviour needs to be contained and controlled. These models typically adhere to a behavioral or social learning perspective. Treatment is geared toward changing reinforcement schedules to reduce undesired behaviour as well as toward teaching social skills to increase

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the likelihood that youth will use socially appropriate strategies to have their needs met. In this paper we argue that, despite the usefulness of some traditional treatment strategies when employed within certain contexts, these interventions are often of limited value in working with youth who have developed internal working models of adults as rejecting, punitive and untrustworthy. The reliance of traditional treatment programs on behavioral strategies that emphasize control and containment of behaviour can, in effect, undermine already fragile attachments of troubled youth to adults and instigate power struggles that inevitably fail in helping youth to develop a sense of personal responsibility for and control of their actions. We propose that attachment theory offers a framework for a fundamentally different approach to working with troubled youth; an approach that begins with an appreciation of the youth's internal working models of self and other. This article reviews the process of transformation of a "traditional" control-focused program into a program that is guided by attachment theory. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: getinfo@haworth.com]*

TRADITIONAL MODELS OF RESIDENTIAL CARE: WHY ATTEMPTS TO CONTROL FAIL

Families or communities identify youth requiring interventions out of concern or fear of their behaviour. These behaviours are generally one of two extremes, "acting out" (violence toward others) or "acting in" (violence toward self). Interventions tend to focus on controlling the problem behaviours and establishing adult control and authority.

The focus on control appears commonsensical. Certainly the extreme behaviours seem to call out for help in regaining equilibrium. Most youth care professionals have witnessed youth in apparently uncontrollable rages striking out at everyone and everything. Perhaps even more disturbing is witnessing grief, rage or fear turned in; youth who self-harm or destroy things they value. Sometimes these acts appear to be direct appeals from the youth to be controlled and contained. In such acute circumstances intrusive, sometimes coercive, control is appropriate as a last resort.

Providing this control can be very satisfying for caregivers. In a profession where one's personal effectiveness as an agent of change is often hard to measure, there is great satisfaction from acting

definitively, with measurable and immediate effect. In addition, youth generally are referred to programs by communities with the expectation that they will be brought under control and care givers are rewarded for their skill in controlling youth. Is it any wonder that as caregivers we often make the mistake of thinking that "bringing the situation under control" is the whole solution rather than only a small part of the solution?

Many youth residential programs rely on adaptations of behaviour modification strategies to provide structure and control. These models of practice use systems of points and levels that are enforced through progressively coercive control, deprivation of recreational/social activities, and social distancing or isolation. Although these strategies are used in the best interests of youth, there are good reasons to challenge the logic behind their use. Most critical in this regard is the fact that internal attributions and acceptance of personal responsibility for behaviour is unlikely to occur in situations where individuals believe that their behaviour is controlled by others or situations around them. When youth believe that caregivers, with whom they have a minimal relationship, little trust and no interest in pleasing, are trying to control their behaviour they are inclined to reject their efforts. Even if caregivers can be successful in producing some amount of behaviour change within the treatment context, reviews of outcome efficacy for the treatment of conduct disorder suggest that simple behavioral interventions or social skills training alone do not produce reliable long term reductions in undesired behaviour that generalize across situations (Kazdin 1987; Moretti, Holland & Moore, 1995; Offord & Bennett, 1994).

There are other reasons to question the efficacy of control-focused interventions. VanderVen (1994) summarizes the effect of control-focus on both staff and youth:

> At another level of control are the bureaucratic and rigid organizations that administer these programs. They also are hierarchical and authority-driven to keep staff controlled just as the staff controls the children. Thus, the programs are often adversarial: staff versus administration; children versus staff; often children versus children. A culture driven to evade and bypass control develops and provides the driving force for the activi-

> ties and interactions that take place . . . Such insidious frameworks so distort the process of learning to live constructively that they create more of the very 'sickness' they are supposedly modifying. Applied to abused and neglected children, such practices certainly enhance the sense of being rejected, victimized, and vulnerable. (pg. 29)

When these strategies fail to reduce aggressive behaviour we blame "incorrigible" youth for failing to respond rather than question the model of practice. Frequently youth become criminalized and are diverted into the criminal justice system rather than into health or social services systems. Despite the failure of these programs, they continue to be supported by the community-at-large with admonitions to the staff that interventions must be harsher because clearly the youth have yet to "learn their lesson." Little consideration is given to the notion that youth are, indeed, learning lessons but not the ones intended. The lesson we need to learn is that harsh external controls do little to engender the development of an internal sense of responsibility and control and, in fact, do much to undermine it.

TRANSFORMING RESIDENTIAL CARE: "FROM CONTROL TO CONNECTION"

The Orinoco program represents a concerted effort to build a program that works with attachment dynamics between troubled youth, their families, childcare and nursing staff and other service providers in an integrated and systemic fashion. This shift in model of practice from "control to connection" has been arduous. It has required the commitment of agency administrators to sponsor a program that is contrary to public demands for retribution. It has challenged front-line staff to put aside familiar behavioral interventions and develop new strategies designed to connect with troubled youth rather than simply contain and control their behaviour (Leaf, 1995).

Prior to our reorganization, the program possessed many characteristics typical of institutional programs for adolescents. The youth in the program were defined as emotionally-ill and were "treated" in isolation from their community. Youth were admitted to the pro-

gram only after their community could demonstrate that all resources within the community had been tried and had failed. The referral system encouraged communities to view troubled youth in terms of their symptoms rather than underlying dynamics and to adopt the view of the youth as the "identified patient." The referral system also encouraged communities to view themselves as incompetent, as unable to care for troubled youth.

The communities were encouraged to believe that we as the "experts" would fix the youth and return a model citizen, an expectation that we consistently could not meet. Although we did have some success in teaching youth to live in institutions, this improvement often did not translate into improvement in the community. The home communities were understandably reluctant to accept the youth back because they were not "fixed." As a result, communities covertly or overtly struggled to prevent the youths' return. These youth languished in the institution and actually became worse as the realization that they didn't belong anywhere sank in. Not only was there a heavy human cost to pay, this logjam of disenfranchised youth within the institution prevented new admissions. The flow of youth through the institution dwindled and the agency came under fire as inaccessible and not cost-effective.

In addition to these structural problems in the referral and admission system, there were some fundamental problems with the model of practice. Childcare and nursing staff implemented a behaviour modification system of progressively increasing levels of control and containment. These ranged from loss of privileges and freedoms to physical restraint to forced confinement and seclusion, and in many cases, to drug regimes for behaviour management. In the pursuit of consistency, staff endeavoured to apply a universal set of institutional rules and regulations across all youth and all situations regardless of individual circumstance and individual needs. Responsibility and accountability amongst the staff was diffuse as virtually all decisions affecting the youths' life was determined by the entire staff group and in reference to the rules and regulations of the unit. This group-think process resulted in extremely slow and cumbersome decision making. The decisions rendered by this process were made in terms of how "fair" the other youth would feel the decision was, whether the youth concerned "deserved" a conse-

quence or new privilege, and how "safe" this decision would be in terms of staff physical safety. The youths' clinical needs took a backseat to these factors.

The final but probably most significant feature of the old model of practice was the definition of professionalism and therapeutic relationships. In the interests of not being seen to "play favourites" or let the youth think they were "getting to you," staff assignments to youth were rotated on a daily basis in order to prevent "unprofessional" relationships from developing. Staff were supervised and reprimanded for developing "unhealthy" attachments to particular youth. In fact, the only truly therapeutic relationships were covert relationships. The restriction of the development of meaningful attachments between youth and staff stemmed from a belief that these relationships could easily spin out of control and beyond the boundaries what would be therapeutic. Regrettably, our belief that control was the goal and connection was a threat to control meant that both youth and staff were left with a feeling that the relationship was artificial and uncaring. These relationship qualities were clearly not helpful in motivating staff and youth to work together as a team.

The effect of the model of practice was to create warring camps: youth versus staff, youth versus youth, and staff versus staff. The youth, already predisposed to distrust adults and rebel against authority, were pitted against a staff group attempting to impose a rigid and institutional structure. The "fairness ethic" meant interventions were attempted without regard to individual youths' needs, capacity to understand, or empathic accommodation to shifting circumstances. The youth, led to expect "fairness," inevitably felt that their peers had received special treatment and punished these peers, the staff, or both. Throughout these dynamics the staff were expected to deny their own and the youth's emotional response to this artificial and coercive setting. This led to conflict between staff. Inevitably, staff and youth would "up the ante" and staff would find themselves trapped in a cycle of conflict that would lead to increasingly violent confrontations until everyone was metaphorically painted into a corner. The staff group would feel unsafe and "lock down" the unit. The youth, feeling cornered and panicked, would fight back and everyone would be trapped in this standoff for days, sometimes weeks. Staff were often injured during restraints of

youth or physically attacked. Youth were injured in restraints or self-harmed in desperation. These standoffs provided clear "proof" of the dangerousness of the youth and the need for even more coercive control strategies. This cycle of extreme measures prompting extreme behaviours became self-perpetuating. The goal for staff became to make it through the shift without injury or incident rather than to achieve any therapeutic task with the youth. Fear for physical and emotional safety was high; morale was low.

The Move to Attachment Theory

There is great irony in the fact that we are in a business dedicated to facilitating change in others but we are reluctant to face the need for change in ourselves. The process of change in the Orinoco program at The Maples was instigated by several factors. One important source of influence was the significant changes in the Provincial Mental Health Act and enactment of the Canadian Charter of Rights and Freedoms. These legislative changes increased pressure to recognize the rights of youth and demanded greater accountability for the quality of care for youth-in-care. These changes were accompanied by growing pressure to critically examine the efficacy of practice. Questions were posed such as: "How do we know what we are doing here is working?" "If we are not having any lasting effect helping the youth with their problems is it possible that we are part of the problem?" "Have we looked at the literature in the field lately?"

This combination of factors made it impossible to deny the limitations of our approach and the need for change. "Solutions are dictated by how you frame the problem" became a guiding principle in our rethinking youth care. If the control-focus paradigm leads to divisiveness and violence, what paradigm will lead to greater harmony and peace in human relations? We searched for a model that would help us understand the *meaning* of aggression and violence in our relationships with youth. Intuitively we understood that the youth's "distancing" behaviours were paradoxically related to a desire to be connected. Perhaps it was more important to understand the function of violence, aggression and other troubling behaviours in the interactive process of relationships rather than controlling the behaviours per se.

Attachment theory as an over-arching guide to practice has been gaining acceptance in the field of youth care programs. Brendtro and Ness in their text, *Reeducating Troubled Youth* (1983), emphasized the primacy of relationships in youth care but did not explicitly refer to Bowlby's (1969, 1973) model. Henry Maier (1987) was among the first to explicitly identify attachment theory in youth care literature as a means of understanding conduct disorder and formulating interventions. Our agency's senior psychiatrist, Dr. Holland, drew heavily on Bowlby's pioneering work in restructuring a sister program at the Maples three years earlier. The initial evaluation work on this program was promising (Holland, Moretti, Verlaan, & Peterson, 1993; Moretti, Holland, & Peterson, 1994). This new project of restructuring the Orinoco Program was an opportunity to further explore, expand and evaluate the application of attachment theory in assisting troubled youth and their families.

Attachment Theory

Bowlby (1969) was the first to conceptualize attachment as a fundamental human need. It is a process that draws us together for the survival of the individual and the species. It pushes us inexorably toward others. The drive to maintain a balance of connectedness and separation in order to ensure a sense of felt security is a constant in our relationships. Attachment dynamics represent an ongoing process of monitoring relative safety and risk in preserving this balance. When the attachment system is activated because of perceived threat of abandonment or engulfment we experience heightened levels of distress. This distress propels us to take action to regain felt security (the balance of connection and separateness). It is the perceived rather than objective level of threat that determines how individuals respond. Individual differences in attachment style reflect different attachment histories as well as different temperaments. (For a current and comprehensive description and analysis of attachment theory see Rutter, 1995.)

We suggest that from the point of conception, through birth and life-span development, individuals develop an attachment style and history. This cumulative history of the attachment process creates an "internal working model," a collection of feelings, beliefs and strategies about people and relationships that is continuously tested and

modified. Characteristics of the infant and primary caregiver(s) interact and, over time, unique patterns of behaviour emerge reflecting underlying beliefs about self and others. Repeated experiences in early relationships form the basis of general conclusions about whether one possesses qualities that attract caregiving and benevolence of attachment figures as well as the degree to which others possess the capacity and predisposition to provide nurturance and protection.

Using the attachment perspective we began to look more carefully at the cumulative life experiences of the youth in our care and at how these experiences have resulted in internalized working models that colour their understanding of interactions with others and shape their behaviours, including their expressions of attachment and separation needs. From this perspective their troublesome behaviours could be seen as reflecting the conclusions they have reached about themselves in relation to others and their attempts to maintain a balance of connectedness and separation, however dysfunctional these attempts appeared to be to us. With this new paradigm for understanding behaviour we began to look more closely at the youths' problem behaviours including their attempts negatively to control and manipulate as efforts to connect and engage with others at a very fundamental level.

Our youth, like all individuals, attempt to engage others in ways that are consistent with their working models of self and others and consistent with their past experiences of care. Their past experiences often contain recurring themes of inconsistent or ambivalent care, neglect, abuse or abandonment. They often have learned that aggression and violence are integral elements of close relationships. In many cases they have developed aggressive patterns to force reluctant caregivers into responding (Crittenden, 1992). These youth typically provoke aggressive and rejecting responses to their attachment overtures. This dynamic of mutual aggression and violence is the "glue" of their relationships and is the hallmark of abusive relationships in general (Dutton, Saunders, Starzomski, & Bartholomew, 1994; Bartholomew, 1990). From their perspective, youth care programs with a control-orientation offer little in the way of new experiences and serve to confirm their beliefs about self as "bad," unworthy, and unlovable and others as rejecting and coercive.

Making the shift to the attachment paradigm provides new insight

into otherwise confounding behaviours. Learning to understand troublesome behaviours as attempts to maintain even conflictual attachments yields a revolutionary paradigm with new intervention strategies. Our orientation shifted from imposing treatment interventions to providing long-term care strategies for troubled youth and their caregivers. These strategies which place priority on developing and maintaining relationships rather than overt control can, at first glance, appear ill-advised and indulgent, even dangerous. The strategies require considerable emotional investment from staff as their own attachment needs and dynamics are challenged. Nevertheless, despite the increased "noise" (literal and figurative) of this model, working with, rather than against, attachment dynamics is more likely to help our youth modify their beliefs about self and others and modify their concomitant behaviours.

WORKING FROM ATTACHMENT PRINCIPLES NOT RULES

Programs that are rule-driven limit the capacity for staff to respond creatively to the individual needs and capabilities of youth as well as unique circumstances. Rule-driven programs encourage oppositional youth to pursue new ways to circumvent the rules and staff to focus on identifying and punishing rather than understanding troublesome behaviours. As part of the process of developing a new model of practice, the Clinical Team created a program (see Figure 1) that operated on a basis of guiding principles rather than rules. Seven principles were developed that provide a basis for the philosophy, structure and process of the Orinoco program.

Principle 1: All Behaviour Has Meaning. The Meaning of Behaviour Is Revealed by Understanding the Internal Working Model of the Person Generating the Behaviour.

This principle is difficult to maintain in the face of the full spectrum of troublesome behaviours our youth demonstrate. It requires putting aside judgments about behaviours as good or bad. Behaviour represents what youth have learned as a function of their

FIGURE 1. Orinoco Program Description

Program Description:
The Orinoco C.A.R.E. (Caregiver, Adolescent Resource Enhancement) Program is designed to provide adolescents and their families with an intensive short term intervention, a Care Plan, and transition phase back into full-time community living. Family is defined broadly to include natural, step, or adoptive parents, extended family members, foster parents, or child care workers.

The short term intervention consists of a three month, Monday to Friday residential component and two weeks of community-based support. The transition phase is tailored to the individual needs of the family and youth. Subsequent to the transition phase, support services are available to the youth and family until the youth's nineteenth birthday. These services include Outreach consultation and support to the Care Plan developed for the youth and family as well as Respite. Respite services are intended to help youth and family bridge stressful times and preserve attachments/placements by providing a brief "holiday" of up to two weeks for the youth at The Maples. Respite is arranged by the Outreach worker in consultation with the youth and family.

The general goal of the program is to increase each family's capacity for constructive problem solving and mutual support in moving toward individual life goals. This is done in the context of each youth's unique social environment with an emphasis on maintaining and enhancing existing attachment relationships.

Specific attachment goals include:

- To enhance family communication and problem-solving capabilities so that stresses are decreased and family members can better support each other.
- To enhance education or employment readiness to enable the youth to experience a more productive identity and to enhance self-esteem.
- To build problem-solving skills at the personal level through participation in a model of group living based on respectful relationships.
- To provide recreation and leisure opportunities in order to enhance social skills.
- To work with other resources to coordinate services appropriate to the needs of the family.

Caregiver commitment:
In keeping with the program philosophy of enhancing all resources involved in the care of the youth, the program provides opportunities for parents or alternate caregivers to participate. These include a weekly group meeting with all parents and caregivers to share experiences, explore developmental issues, to discuss communication and problem-solving strategies, and to develop self-care strategies. In addition to the support group, weekly sessions with the social worker are available for family, marital or individual therapy.

unique life experiences and should be respected as their best efforts to maintain a balance of connectedness and separation. By putting aside dichotomous judgments and respecting the youths' world-view, we can clear the way for understanding their internal working model. Only then is it possible to establish a therapeutic alliance.

Integral to this first principle is our belief that not only does all behaviour have meaning but that all behaviour is directly or indirectly tied to attachment processes. Our youths' attachment behaviours tend toward the outer limits of social norms and reflect the idiosyncratic and extreme experiences they have encountered. The failure of traditional forms of social control on their behaviour is well demonstrated by the time they are referred to our agency. This failure occurs because traditional forms of social control presume an attachment history that produces an internal working model which interprets the social controls as acceptable forms of caring. Our youth have not had that "mainstream" attachment history and they often interpret conventional parenting or "treatment" strategies as coercive and threatening. When we came to understand the youths' interpretation of our well-intentioned efforts of social control and training we sharply reduced or eliminated intervention strategies that arise from the behaviour control tradition. We abandoned using point and level systems and other strategies that focus exclusively on behavioral "symptoms." Our focus has shifted to understanding underlying attachment issues and working with the attachment dynamics to connect first . . . control will follow.

From a daily practice perspective, this has meant removing as many physical and philosophical barriers to establishing empathic relations with the youth as possible. Doors that automatically locked the youth within the building have been disarmed and are now locked in only the most extreme circumstances. The staff office is no longer an inviolate sanctum that excludes youth. We literally and symbolically disarmed the seclusion room by removing the locked door. Physical restraints are all but eliminated. We strive to eradicate all overt and covert barriers between the staff and youth to discourage "us against them" dynamics. We changed our language to reflect our new orientation. We now implement "care" strategies rather than "treatment" interventions. Staff involvement with the youth is no longer conditional on the youths' good beha-

viour. It is the staff's responsibility to make the first move and to persevere with efforts to connect with the youth.

Principle 2: Early and Repeated Experiences with People Who Care for Us Set a Foundation for Our Internal Working Models of Relationships with Self and Others. Our Earliest Experiences Have a Profound Effect on How We Approach Relationships, School, Work and Play.

In contrast to some schools of psychological thought which view the individual as an independent entity, the attachment perspective is a psychology of relationships. The individual can only be understood in the context of relationships with others and with systems (family, community, school, etc.). Early life experiences shape the individual internal working model of self as worthy of care and others as likely to meet attachment needs. The internal working model shaped in these early years is not immutable but change is slow.

Adopting this principle has altered the program structurally. There is now a far greater emphasis on collecting an extensive social history that focuses on early and repeated attachment dynamics within the family. The social history is one component of a plan for care which is developed for each youth. It provides insight into the formation and current nature of the youths' internal working model thus providing a means for interpreting the underlying meaning of their behaviour. This social history includes not just the youth's experience but also the parent's experience of being parented. This latter investigation acknowledges the inter-generational aspect of attachment dynamics (Steele, Steele & Model, 1991; Main & Goldwyn, 1984). Included in the social history are explorations of attachments the youth may have formed in the extended family or outside of the family.

Principle 3: Biological Legacies such as Cognitive and Physical Capabilities Are an Interactive Part of Our Experience and Contribute to Our Working Model of Relationships with Self and Others.

Individuals vary widely in their cognitive and physical functioning. At Orinoco we endeavour to avoid qualitative judgments that

describe one individual as better than another. We do, however, stress the importance of identifying and accommodating to the unique capacities of each youth (e.g., attention deficits, hyperactivity, expressive and receptive language disorders, intellectual functioning, etc.). The importance of caregiver adjustment and attunement to youth characteristics in fostering security and adaptive development is well documented (Tronick, Ricks & Cohn, 1982). This principle has resulted in a number of structural changes to the program. We do not attempt to make individual youth conform to a standard "treatment" regime. Instead we strive to accommodate to each youth's unique capabilities to attend to tasks and, most significantly, their capacity to understand and manage attachment dynamics. We adapt our communication style to meet their capabilities. There is not a great deal of "talk therapy" or group therapy. Rather than attempt to work in an abstract language-based mode, we rely more on experiential learning. Rather than follow a rigid curriculum we provide educational, vocational and recreational options. The program structure provides a context for the attachment process to be explored rather than to achieve specific outcomes. The flow of events in the program provides "teaching moments" to inject new information about human relations. Sometimes the moments are entirely experiential and completely non-verbal.

Principle 4: Internal Working Models Are "Works in Progress" Developing in the Context of Relationships and Experience. These Models Are Constantly Under Revision Based on Experience. Experience Can Be Added to but not Subtracted from.

This principle expands on the theme of principle two and offers optimism about the potential for change. Early and repeated experiences with caregivers provide the foundation of our internal working models but subsequent experience can modify our belief system.

Our youth have developed an internal working model and are relatively predictable. Their behaviour generally elicits predictable responses from others that serve to confirm for the youth their internal working model. We cannot change their internal working models by trying to erase or discount their past experience. We can, however, contribute to change by adding new experiences. Repeated often enough this experience creates dissonance in the inter-

nal working model. When this system is out of balance there is the opportunity for reintegration and a modification to the internal working model. This is the therapeutic process we attempt to achieve.

This formulation of the therapeutic process led to structural and practice changes in the program. If our goal is to create alternative experiences of relations with others for the youth, how can we minimize the power struggles that only serve to confirm their beliefs about others? We adopted a strategy of "doing *with* rather than doing *to*." Although the program has a structure (school in the morning, work experience in the afternoon, recreation in the evening), each child care counsellor has the freedom to modify the structure to meet the needs of the situation. What a youth does on any given day is negotiated between the youth and their staff. The staff are supported to "be interesting people with interesting things to do." They are encouraged to "engage the youth rather than supervise them."

In many respects it is irrelevant what activity the youth and staff choose because attachment dynamics are always present. By accommodating to the youths' attachment style and priorities, the childcare staff minimize compliance struggles that serve to confirm the "adult as enemy" position held by many of our youth. This would be merely indulgent if the staff were not focused on extracting maximum effect from every activity to illustrate and inform the youth about the nature of human interactions. This strategy maximizes opportunities for the youth to experience success rather than another string of failures with a punishing adult. This process helps the youth begin redefining themselves as more socially competent and from this secure base venture into the greater challenge of more mainstream social settings.

Principle 5: Interpersonal Relationships Are a Process of Continuous and Reciprocal Interplay of Each Person's Internal Working Model with the Others'. It Is not Possible to Hold Yourself Apart from this Interplay.

This principle encapsulates a shift in our beliefs about the nature of the relationship between youth and staff. It acknowledges that the experience of engaging in a relationship is a reciprocal act that

triggers attachment dynamics for both participants. That is to say the staff cannot avoid bringing at least some of their own "baggage" into their relationships with the youth. This is not a drawback to the therapeutic process–properly managed it becomes an asset.

Each youth is provided with a primary staff on each of the day and evening shifts. These assignments or "units of care" are for the duration of the program regardless of the initial "goodness of fit." The program thus minimizes the number of people (attachments) the youth must manage and intensifies these two primary relationships. In addition this strategy minimizes delay and confusion created by previous "group-think" processes, maximizes accountability and creativity for the staff, and prevents staff from avoiding their primary youth when the going gets tough. The staff strive to "respond not react" to the youths' provocative or heart-wrenching behaviours.

The work culture encourages being "authentic" with the youth and each other; expressing emotional response to conflict and working through issues. The youths' attachment needs, however, always take preeminence. Staff are encouraged to be honest with their frustrations but they are not permitted to give up on or reject the youth. "I am completely frustrated and angry with you right now and need a little space but I will not give up on you and our relationship."

The work culture also embraces rather than condemns conflict. Every crisis is an opportunity. Conflict means that some aspect of the youths' internal working model is activated and available for investigation. In our old model of practice conflict represented a failure and physical restraint and seclusion a successful resolution. In our new model of practice conflict represents an opportunity and physical restraint and seclusion a failure in our ability to work empathically with the youth and demonstrate for them a new possibility for resolution of conflicts.

A support group for parents and alternate caregivers as well as individual therapy sessions are also used to help parents and caregivers recognize their role in cycles of conflict with youth. Through dialogue the parents and caregivers explore their own attachment issues and how these shape their view of the world and their relationship with the youth. In systems theory language our goal is to

help parents and caregivers understand that the youth is not the "identified patient" and that change must occur within the entire family or caregiving system.

Principle 6: We Understand Ourselves in Relation to Others. Our Sense of Self Includes Our Sense of How Others View Us and Respond to Us.

Prior to the reorganization of the program we adopted a common practice of reductionism in treatment. That is, we attempted to provide "treatment" to individual youth while they were apart from others and their social context. This practice is flawed from two perspectives. One, our youth often do not learn well in the abstract and many of the lessons learned through these exercises were contradicted and overtaken by their practical experience. Two, these exercises required a fair degree of compliance and often became sources of great conflict as the youth failed to see any relevance between role-playing and real life. If one adopts a more holistic approach to treatment, it becomes clear that changes in our sense of self cannot be effected separate from our social environment. In effect, our sense of self is connected with what we think others think of us.

The Orinoco program can provide an experience of being accepted by others. Many of our youth have had a lifetime of being marginalized by peers and adults. The assignment of permanent primary staff who have the belief that each youth is "good enough" helps create a social context that bolsters the youths' sense of self. A focus on building on strengths rather than focusing on short-comings adds to the process of developing a positive sense of self. A willingness to alter structure to accommodate to areas of strength, interest, or attachment dynamics further aids the process. The catalytic effect of the program experience on attachment issues invariably creates emotional turmoil. The youths' experience of staff as attuned to this turmoil and focused on understanding rather than controlling them has immense therapeutic effect. Working with parents and caregivers to recognize strengths and accomplishments can have a very powerful effect. It is often a novel experience for

parents to interact with other adults who have a positive view of their child.

Principle 7: Enduring Change in an Individual's Behaviour Occurs only when There Is Change in the Internal Working Model Supported by Change in the Systems(s) that One Lives in and There is Sufficient Time, Opportunity and Support to Integrate the New Experience.

The description of our program prior to reorganization amply illustrates the shortcoming of a reductionist approach to treatment. A more holistic or systemic approach to treatment suggests that if attachment dynamics between individuals shape internal working models then any change in one individual will not be sustained unless other powerful person(s) within the system support this change. For this reason we make all youths' admission to the program contingent on the presence of a parent or caregiver who is willing to be a partner in the process. In addition to our efforts to help the youth shift (or start to shift) their internal working model, we endeavour to help the parents or alternate caregivers as well as the larger caregiving systems to reframe their concerns as attachment issues that require intervention at a macro systems level. Support to the parents or alternate caregivers is at least as important as direct care interventions for the youth.

THE IMPACT OF ADOPTING AN ATTACHMENT PERSPECTIVE

The impact of adopting an attachment perspective on the structure and practice in the program has been profound. There is a renewed vitality and substantial improvement in virtually every aspect of the program's operation.

Program Atmosphere and Structure. When contrasted to previous versions of the Orinoco program or current alternative programs within the agency, there is a palpable difference in the "feel" of the program. This difference persists despite three years of operation, long after any novelty effect has worn off. Shifting the focus of the program from short-term outcome (behaviour

management) to the long-term process of change through a therapeutic attachment and separation process has vastly reduced the "us against them" atmosphere of mutual antagonism evident in many youth programs. Damage to property, threats of violence or self-harm as well as injuries to staff or youth are markedly reduced. Physical restraints and seclusions have gone from a daily occurrence to a rarity.

This is not to suggest that peace reigns on Orinoco–quite the opposite. The building vibrates with noise and energy as the youth alternately exult and despair with their life struggles. What has changed is the staff's role in this drama. No longer relegated to "enforcers" who struggle to keep the peace, the staff are significant participants in the youths' lives. By recognizing and working with the youths' attachment dynamics the staff have relevance and value to the youth. It is this act of becoming attuned to the youths' attachment dynamics, creating a greater sense of psychological safety and mutuality that has contributed to the program's change in atmosphere.

Another qualitative shift has been an increase in activity. As noted earlier, programs focused on behaviour control often reach a stalemate–the result of a spiralling cycle of constraints placed on acting out youth who act out further in reaction to the controls and so on. Stepping outside of the control paradigm and into the attachment paradigm minimizes these standoffs and maximizes the potential for productive relationships to develop between staff and youth. This can create a sense of barely controlled chaos in the program but this is quite appealing to youth at a developmental stage where action and novelty are important.

The three month duration of the program creates a beginning, middle, and end to the experience for the youth in contrast to the indeterminate "sentence" of the previous program format. In addition, the weekly separation and rapprochement created by spending weekends at home "turns up the heat" on attachment issues. Indeed, sometimes the intensity of how attachment issues are played out in the caregiver-youth relationship can be exhausting making it absolutely necessary to provide adequate support to staff and "breathing space" for both staff and youth. The new program format permits staff to be attuned to attachment issues and make the

clinical judgment that the youth needs a "time out" from routine daily expectations. In other circumstances, the youth may stay at home longer than just weekends if this is indicated or even go to alternate placements on the weekend if required.

Patterns of Practice: Front Line Staff. The focus on attachment issues created by the units of care, the catalysts of weekly separations and reunions as well as the three month cycle of the program combine to create a pressure-cooker effect. Although extremely challenged, the staff thrive in this work context which provides an opportunity for clinical independence and creativity, a greater sense of efficacy and of professional and personal growth. There are many similarities in technique to Redl and Wineman's (1952) pioneering work in Life Space Interview management and education strategies. The addition of an attachment-based perspective brings improved therapeutic relationships through improved "empathic attunement" to individual youth psychosocial and biological developmental stages.

The pressure-cooker effect creates the need for greater support from the clinical team for the staff to work through their emotional turmoil in a safe venue. The need for this support diminishes over time as the individual staff gains experience and maturity and as the staff group becomes more experienced at mutual support. Using attachment dynamics to reframe aggressive or other distressing behaviours is key to maintaining individual and group staff equilibrium. The intensity of the program as well as the beginning, middle and end of the experience created by this format helps create a greater sense of identity and achievement in the staff group. The program has the best record in the agency for staff retention and absences for illness or injury.

Patterns of Practice: The Clinical Team. The Clinical Team consists of a full-time program coordinator, a full-time social worker and a quarter-time psychiatrist. Although each individual has areas of responsibility and expertise, their primary role is one of consultant to the care-givers (staff, parents, alternates). This is particularly true of the psychiatrist's role which has shifted from direct service to the youth to indirect service through the staff who "live" the therapeutic experience with the youth and caregivers. The staff individually and collectively experience "crises of faith" during the

program cycles and need support and redirection from the Clinical Team who have the benefit of a degree of distance from the intensity of the attachment/separation processes. Clinical direction is always framed in terms of attachment dynamics and moderates the impulse to move toward control or distancing strategies to resolve attachment conflicts.

Impact on Youth. The response of the youth to the Orinoco experience is as varied as their attachment histories. There are, however, some common themes. There is general agreement among the youth that the program is unlike any other. The experience of intense involvement with adults willing to make the effort to understand their world view without prejudice is novel and intriguing. The resilience of the adults in the face of challenging behaviours and their efforts to eschew control or distancing strategies is paradoxical. It is simultaneously appealing and frightening. Many if not most youth in the program develop relationships with their primary staff that are unprecedented in their previous experience of relationships with adults. There are no "miracle cures" but the process of working through attachment/separation conflicts with their staff shakes up the youths' internal working models and their capacity for empathy and mutuality in relationships is enhanced. Although the primary focus is psychological growth, many youth grow significantly in the realms of vocational readiness, academic achievement and recreational skills.

Impact on Parents, Alternate Caregivers, and the Service Systems. Predictably, the parents or alternate caregivers are initially disappointed that there is no quick fix for what they view as the youths' problems. Through the process of regular contact with the child care or nursing staff as well as individual, family or group work with the social worker, they generally come to accept a more holistic perspective on the problems in their family system and the solutions available. Most of the parents and alternates come to value the Parent Support Group with its focus on developing self-care strategies. Many parents also value the experience of working with helping professionals who endeavour to not directly or indirectly judge them to be "bad parents."

In some cases family separation is the outcome of our program interventions. Resolving the dilemma of "ambivalent or conditional attachment" through agreeing to live separately is often the best of

two difficult choices. Helping parents and youth come to this decision without an overwhelming sense of guilt and failure has helped many families.

The attachment perspective has also proven valuable in helping the larger care-giving system to more effectively organize the delivery of care. Using an attachment formulation for understanding the genesis and function of the problem behaviours helps professionals from diverse agencies such as Social Service, Corrections, and Education arrive at collaborative rather than contradictory interventions.

Impact on the Agency. The Orinoco program has brought a renewed sense of purpose and excitement to the agency in general. The Orinoco team's enthusiasm for the challenge of working with troubled youth and families has spread from the staff group to infect other areas as well. In addition to this boost in spirits, the Orinoco program has had some tangible benefits as well.

The program format has at least doubled the number of youth and families served on an annual basis with a thirty percent decrease in staffing. This reduction in staffing costs is augmented by savings garnered from lower injury and illness absences. Further savings in staff costs are gained by not having to replace vacationing staff as all vacations are taken between program cycles. The periods between cycles are also used for team-building and training events to rejuvenate the staff group. There is low staff turnover thus reducing training costs and team-building efforts.

The shift to attachment orientation with its reduction in violence has also reduced the hard costs of maintaining the physical plant and repairing or replacing furniture and other accessories in the program. This factor has helped to create and maintain a warmer, more inviting physical space in an otherwise cold institutional building.

SUMMARY

In summary, the shift to an attachment paradigm for understanding conduct disorder has given new direction and energy to a program that was nearing clinical and operational "gridlock" by virtue of its previous control focus. What had become a dead-end placement for disaffiliated youth has become a revitalized program that works with rather than against attachment dynamics. The qualitative improve-

ment in this program is palpable for those of us who have experienced the process of change. Complementing our efforts to work with attachment dynamics is our goal to empirically evaluate the process of change over the course of our new program. Initial results are encouraging (Moore, 1995, 1996) and will hopefully lead to a greater understanding of how attachment oriented interventions impact on the internal working models of troubled youth.

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BIOGRAPHICAL NOTES

Ken Moore started at The Maples eleven years ago as a "front line" child care counsellor and has come up through the ranks to his current position as Program Coordinator. Ken has collaborated with Drs. Holland and Moretti over the past four years in program development and implementation using attachment theory to guide practice. Staff, agency, and community program development and evaluation as well as research and writing in child and youth care are all current interests.

Marlene Moretti is a Registered Psychologist and Associate Professor in the Psychology Department at Simon Fraser University. Marlene also is a consultant to The Maples. Her research interests include developmental issues in psychopathology and the emergence of self, and treatment efficacy. Marlene has co-authored several papers on Maples programs or research projects as well as numerous papers in her academic career at Simon Fraser University.

Roy Holland is a Child and Adolescent Psychiatrist with over thirty years of experience in child and youth care. He has a private practice, consults to several community programs, and is the Senior Psychiatrist at The Maples. Roy is the clinical driving force behind the highly-regarded Response Program and the clinical director of the Orinoco Program at The Maples. Roy has co-authored two papers on the Response Program. Current interests include developing attachment-based community programs, treatment efficacy, and further development of attachment theory.