



# Why a Therapeutic Community Approach to Residential Child Care?

DAMIEN MCLELLAN

## Abstract

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This paper is based on a plenary presentation I made to the “Where is Home?” Conference in Malta, 12-14 March, 2009. The presentation was a spontaneous commentary on ten slides shown to the participants who were all professionals concerned with residential child care. The slides were intended to give the conference an indication of the road ahead, should they decide to journey in the direction of a therapeutic community approach to residential child care. I am a consultant psychotherapist to several child care centres in Ireland that work from a therapeutic community approach and the residential centres in Malta had expressed an interest in this work. I have since written up these un-scripted comments and added my thinking on the controversial subject of the use of punishment and sanctions in residential child care.

Key words: Residential Child Care, Therapeutic Community Approach

The desire to be at home is an intensely felt human need. Even people fortunate enough to afford a holiday, “to go travelling, to Paris, London, or Rome” often realise, as the song goes, that “it’s so much nicer to come home”. When we are away from home for prolonged periods we also long to be back in our safe, secure and familiar surroundings, and, if we are lucky, with people we love and who also love us. This longing has such a physical feeling attached to it that we call it ‘homesickness’. What are the implications of this commonly felt need, therefore, for the significant number of children and young people throughout the world who need to live in residential care?

One implication (and this is so obvious that it may often be overlooked) is that children in residential care are by definition *not* at home and may be in a permanent state of loss because of this; they may also be feeling abandoned and unloved by their families. I also believe that the historic abuse and neglect of children in residential care may understandably cause the authorities responsible for the children currently in residential care to be more concerned with their safety and welfare rather than with their therapeutic and mental health needs. Residential care continues to be regarded as ‘the last resort’ and foster care ‘the preferred option’. However, a recent and significant research study proposes that the mental health needs of certain children can be appropriately met in specialised residential settings, especially in the following circumstances:

- When there is a deficit in attachment-forming capacity and a young person could benefit from having a range of carers
- When a young person has a history of having abused other children
- When a young person feels threatened by the prospect of living in a family or needs respite from it
- When multiple potential adult attachment figures might forestall a young person from emotionally abandoning his or her own parents
- When the emotional load of caring for a very disturbed or chaotic young person is best distributed among a number of carers
- When the young person prefers residential care to any form of family care, and would sabotage family care if it were provided (Clough, Bullock, & Ward, 2006:, p. 71)).

The same research suggested that residential child care could possibly offer the following important benefits:

- Providing stability and a stimulating environment
- Widening cultural and educational horizons
- Creating a framework for emotionally secure relationships with adults
- Providing a setting for intensive therapeutic work (*ibid.* 2006).

So, however negatively and perhaps subjectively some people may feel about residential care, at least in the light of the above research it possibly needs to be considered as an option that makes sense and not just as 'the last option' with all the negative connotations that this phrase implies. It could also be argued that all children and young people in residential care, by virtue of the fact that they are not at home (because they either do not want to be at home or, much more likely, are not able to be at home) are in effect deprived and disadvantaged. At the very least the alternative care arrangement must not in itself do further harm and at best should be healing and therapeutic.

Children in residential care also need an environment that will meet their needs. John Bowlby (1969) argued convincingly that the attachment by a child to a significant adult is a profound human need and lays down the foundation for future mental health. Abraham Maslow (1968) proposed that human beings have an ascending order of needs from basic physical needs, through gradually meeting safety, love and belonging and esteem needs, and eventually achieving a healthy and confident sense of self. Unfortunately, as Bruno Bettelheim (1990) reflected

Children wish for so much but can arrange so little of their own lives which are so dominated by adults without sympathy for the children's priorities (cited in *Choosing with Care*, HMSO, 1992, p. 1).

I am now convinced that the basic needs of children, as well as the treatment needs of very hurt children can best be met in a therapeutic community or a residential setting working from therapeutic community principles, which are discussed below. Adrian Ward (2003, p. 11) offered a working definition of a therapeutic community as

A specialised unit for children, usually residential and often incorporating education as well as care, and usually organised on the basis of offering planned therapeutic help and support over a period of two or three years. At the heart of this work will be recognition of the need to understand and address the impact on children of traumatic early experience (for example of severe loss, neglect, abuse or extreme attachment difficulties).

There is a strong and historic tradition of therapeutic communities in the United Kingdom which has a distinguished record of successful outcomes with deeply troubled children. One such community, for example, is the Mulberry Bush School which was founded by Barbara Dockar-Drysdale (1990) who worked in close collaboration with Donald Winnicott (1965). Ten

principles today inform the work of the Mulberry Bush and other residential child care centres working along similar lines. (Ward, Kasinski, Pooley and Worthington, 2003)

**1. An emphasis on the value of *groupwork* as a medium both for therapeutic work and in some places for decision-making with the young people.**

Groupwork has long been recognised as a valuable and effective method of meeting the needs of individuals, whether or not the individuals concerned live or work as a group. Residential child care by its very nature involves a group of staff working with a group of young people. Therapeutic communities exploit the healing properties of groups, for example, where the young person can be encouraged both to receive help from the group and, later perhaps, contribute to the wellbeing of the group.

The central principle of this approach is the belief that all members of the community (children as well as staff) can give as well as take in therapeutic exchanges and indeed it is *the community itself* which is therapeutic, rather than (as is more traditional in clinical work) that it is primarily only the staff who engage in therapeutic endeavour (Ward, 2003, p. 33).

**2. A specific commitment to the use of *community meetings* as a medium for both practical and therapeutic business between the group of young people and the staff group.**

Here the two groups who comprise the community, the young people and the staff, meet as a community, everyone having an equal right to speak and be heard. Some meetings may happen in order to agree on happy and ordinary issues, such as the venue for summer holidays; other meetings may need to respond to less happy and more extraordinary situations, such as a young person who is struggling to achieve self-control. Young people who do well seem to go through three stages of growth in community meetings: at the beginning observing others asking for help and being helped; then, being able to ask for help and support; and eventually being able to be part of providing it to others.

**3. Within this group context, a willingness on the part of staff to commit themselves to medium/long-term *individual therapeutic relationships* with young people.**

We will sometimes need to get emotionally involved with some children if we are to be part of their recovery. This means that they will also need to get emotionally involved with us. Therefore it becomes less a job where we can simply give notice and leave when it suits us but more an occupation that occasionally will require us to commit ourselves to seeing through a piece of work once started. For example a young person can become emotionally very dependent on a keyworker, in exactly the same way that a client becomes dependent on the therapist. This dependency, while a temporary phase, is part of the treatment and needs to be taken as seriously by the child care worker as it is by a therapist. A child care worker might therefore have to postpone personal plans in order to see the child safely through this phase. One of the challenges, therefore, of this particular way of working is that it requires a worker to make a deeper commitment to the children than might otherwise be necessary.

**4. An emphasis on the potential for therapeutic communication between staff and young people to arise from *everyday interactions* in daily 'living alongside' each other (i.e. opportunity-led work).**

Visitors to a therapeutic community might ask "but where is the therapy?" It might be glimpsed at structured community meetings, or they might see the young person enjoying a pre-arranged 'Special Time' with their keyworker. But it mostly happens spontaneously and unseen, a young

person taking the chance to share serious feelings with a trusted staff member or a staff member having to confront a young person over a recent incident. The spirit in which the confrontation is done is far more important than how or why it is done. A young person might return from school very angry, throw her books across the room and aggressively ask the member of staff "who are you looking at?" The young person, especially if new to the therapeutic setting, will probably expect to be reprimanded for throwing the books and her anti-social behaviour. She can then project more of her anger on the adult, get some emotional relief out of this and stomp off to her room reassured and comforted that her conclusions about adults being useless are still correct. But, if the adult is first of all able to quell her own personal feelings of panic and anger and secondly is able to remember how unhappy this girl mostly feels inside, she might respond empathically as follows: "You seem to be very upset. What happened?" She might hear the story behind the anger and the book throwing and begin to forge a therapeutic alliance with the girl who up to then has only been able to communicate her internal feelings by dramatising or acting them out.

5. **In daily practice, a commitment to a *personal* and involved style of working, in which the quality of the relationships between young people and staff is seen as playing a central role in the treatment process.**

As explained in the previous example, confronting the young person needs to be done in a personal way; so, for example, not as in 'The staff are very unhappy about what you have done and we need to talk about it' but more like 'I'm very concerned at your behaviour and I'm wondering what is going on for you'. The work is done through the medium of a network of relationships built between the young people and the staff and between the staff and the young people. But at the core of the therapeutic process is the therapeutic alliance built between the young person and the member of staff, where the young person has put out what help he or she needs and the member of staff has made a commitment to try and meet this need.

6. **A commitment to the value of the physical and personal '*environment*' for its contribution to the work.**

The therapeutic community may be where staff work, but more importantly, it is also where the young people live. It is their home. Staff go from their workplace to their own homes. The spaces in which the young people work, learn, eat and sleep should reflect back to them a sense of worth, especially a sense of being worth caring for. Is the environment negatively confirming or positively contradicting their rigid internal working models? (Bowlby, as cited in Holmes, 1993). We need to ask ourselves 'would we live here, would we want our own children to live here, and if they had to, what would we need to change?' Adult initiated Community Meetings could usefully address these issues as the young people may not feel good enough about themselves to ask for better and they may settle for a bland, impersonal and even institutional environment, one that meets not their needs, but the organisation's.

7. **Engagement with *other key systems* in the young person's life, including their family and other personal networks, as well as with their educational, health and other developmental needs.**

When we take young people into our care we also need to embrace the relationships they already have with their families and friends. Some of these relationships may present difficulties for us, but they may also provide opportunities to work with the young people at a very deep level. The therapeutic community approach is also careful not to become over-preoccupied with the young person's emotional process at the expense of paying quality attention to the young person's other needs. It is worth remembering that the desired outcome of all therapy is change and we need to keep in mind the aspects of the young person's behaviour that need to change.

8. The use of *psychodynamic* rather than solely behavioural or cognitive theoretical frameworks to underpin the treatment philosophy, and of *systemic* thinking to interpret connections between people, events and feelings.

While the humanistic approach emphasises feelings and the behaviour/cognitive approach is largely concerned with thinking, the psychodynamic approach asks what is behind the young person's behaviour, what is going on underneath that the young person may not be in touch with. With any person, there is more happening that is pre-conscious and unconscious than is conscious: how the person is feeling or thinking is really only the tip of the iceberg. It makes sense, therefore, to pay particular attention to and to be aware of the inner world of the child. A systemic approach reminds us that 'no man is an island' and that we are all affected by, and in turn we affect, whatever environment we find ourselves in.

9. In internal management structures, an emphasis on each person's role and *potential contribution* to the agreed task and philosophy rather than mainly on status, rank and formal titles.

In the average residential therapeutic community there would be an acceptance that the newest, youngest recruit to the staff team might well bring the potential to make the crucial relationship or intervention with a child that seasoned colleagues may have missed or been unable to make. This could be because this new 'green' member of staff has brought a unique personality trait that proves to be very attractive to the child; or maybe the new staff member has brought a fresh approach or perspective that was missing. A pyramid would normally represent the hierarchy of most organisations, especially those working from the medical model, with the most senior and qualified people at the top and the most junior and least qualified at the bottom. The therapeutic community model would be more accurately represented as a circle, around which each member of staff, regardless of rank, takes an equal place. The young people can be imagined at the centre of this circle, hopefully feeling safe and contained but also free to approach and access anyone on the circle. Equally, all the staff on the circle share responsibility for all of the young people in the circle, not according to any given rank but to their ability to take responsibility.

10. A commitment to the value of a full system of staff support and supervision, including the use of *consultancy*.

The therapeutic community approach as described here appears to be a very demanding setting in which to work: one where open two-way communication is ongoing and often challenging; where involved relationships are encouraged; where staff take advantage of spontaneous incidents to progress therapeutic work; where staff are also expected to commit themselves to the work and all the time to be constantly reflecting on what is going on for them, for the colleagues they are working with and the children and young people they are working for. This would not be possible to carry out in a safe and productive way without there being support and supervision for all involved. When Barbara Dockar-Drysdale stepped down from managing the Mulberry Bush School she became the Consultant Psychotherapist to another residential therapeutic setting, the Cotswold Community, and she continued a tradition in therapeutic communities of bringing to the work an external and un-biased perspective. She knew as well as anyone that the people doing the work, however brilliantly, could very easily lose their sense of direction. The ideal consultant needs to be someone who has made a similar journey and who has the experience to empathise with the staff attempting this demanding task.

On the following morning after giving this plenary session, I was surprised when I realised that I had not mentioned another principle, one that is perhaps the most controversial, although

hopefully this may not now seem too controversial to anyone who has read so far. I believe a defining moment in the journey of a residential centre on the way towards being a healing community is when a decision is taken to abolish punishment. By punishment I mean sanctions of any kind that are intended to cause the young person loss or discomfort, such as loss of pocket money, missing family access meetings or having to go to bed early. I started off with the theme of home and I fully accept that many families are happy families despite the use of punishment, sanctions, grounding, 'naughty steps' and so on. Perhaps the relationships in these families are sufficiently robust and allow everyone to get away with this.

In professional residential care, however, where we are attempting to make healing relationships with children who have been seriously let down, hurt or abused in previous relationships, we cannot risk damage to this slow and often painful process by the use of sanctions. Children will accept punishment and will surprisingly often ask for punishment as it confirms their low opinions of themselves. It is also easier for children to 'do their time', and to suffer whatever consequences there are for their actions – rather than take responsibility for them. In a therapeutic community a child who has done something wrong will probably be first asked something like: "What was that all about?" and then "What are you going to do to make up for it?" Children in therapeutic communities are expected, according to their abilities, to make restitution and reparation for whatever damage they may have done or the pain they may have caused to others. This is a form of 'tough love' which tries to address the causes of the offending behaviour rather than simply dealing with the resultant consequences. It also brings the young person into the decision making process and helps them to repair their own self-esteem and sense of self. A psychodynamic approach would encourage us to assume that a young person who is being oppressive to others may be acting out their oppression – punishment and shaming can only further compound the original hurt. Or, in the words of Don Bosco:

'Charity, patience, gentleness – never degrading rebukes, punishment never. Do good to those you can, evil to no one. This holds among all who live and work with us.'

## Concluding Comments

So, where is home for the children and young people in residential care? In my work recently a 15 year old young person out for a drive asked her keyworker to first drop her off at home to get something before they continued to where they were going. The keyworker needed to ask "Which home?", such was the young person's previous extremely negative attitude to the residential centre where she then lived. The young person named the centre and looked at the child care worker as if she was stupid. It appears that below the surface and behind the behaviour the young person had begun to feel as if she was now at home. She obviously felt safe there, and sometimes she allowed herself to feel minded, wanted, appreciated, respected and loved. She probably had also realised, more importantly, that she belonged there, even if only for the time being.

The poet Robert Frost wrote that "home is the place where, when you have to go there, they have to take you in" and that home was "something you somehow haven't to deserve" (Frost, 1955, p. 38). I believe that at the very least this sense of unconditional caring should be fundamental to the ethos of any 'good enough' residential centre for children and young people.

## References

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- BOWLBY, J. (1969). *Attachment and loss*, vol. 1: *Attachment*, London: Hogarth Press and Institute of Psycho-Analysis.
- CLOUGH, R. BULLOCK, R., & WARD, A. (2006). *What works in residential care: A review of re-search evidence and the practical implications*. London: National Children's Bureau (available as pdf only from [www.ncb.org.uk/nercc](http://www.ncb.org.uk/nercc)).
- DEPARTMENT OF HEALTH (UK) (1992). *Choosing with care: The report of the committee of inquiry into the selection, development and management of staff in children's homes* HMSO: London.
- DOCKAR-DRYSDALE, B. (1990). *The provision of primary experience: Winnicottian work with children and adolescents*. London: Free Association Books.
- FROST, R. (1955). *Selected poems*. London: Penguin Books.
- MASLOW, A. (1968). *Towards a psychology of being*. New York: Van Nostrand.
- WARD, A. KASINSKI, K. POOLEY, J. & WORTHINGTON, A. (Eds.) (2003). *Therapeutic communities for children and young people*. London: Jessica Kingsley.
- WINNICOTT, D.W. (1965). *The maturational processes and the facilitating environment*. London: Hogarth Press.

## Author's note

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### Damien McLellan

M.Phil., MSc. Counselling and Psychotherapy, MIAHIP, first trained in residential child care at the North London Polytechnic and later at the University of Newcastle Upon Tyne. He was Director of Reinden Wood House Therapeutic Community in the UK (1969/81) and managed Prospect House Child Care Centre in Waterford City (1986/95). He also trained in consultancy and community mental health at the Tavistock Clinic, London and subsequently qualified as a psychotherapist in Ireland. As well as teaching at Carlow College, where he leads the MA in Therapeutic Child Care Course, Damien works as a child care consultant and consultant psychotherapist to several child care centres in Ireland, including the Don Bosco organisation. He continues to do direct work with very troubled children and supports children in foster care.

## Erratum

In Volume 12, Number 4, the name of the second author of the article 'Maltreated children who are adjudicated delinquent: An at-risk profile' was inadvertently omitted. The second author was dr. Patricia Stoddard-Dare, Cleveland State University, USA. The correct reference for this article is:

Maltreated children who are adjudicated delinquent: An at-risk profile  
CHRISTOPHER A. MALLETT & PATRICIA STODDARD-DARE

We apologize for this error.

Hans Grietens  
Editor