Creating and Strengthening the Therapeutic System for Treatment Settings Serving Deaf Children

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Abstract

Treating deaf children with severe emotional and behavior problems, especially in residential and alternative school treatment settings, is a demanding undertaking. Finding and retaining skilled mental health paraprofessionals are continual challenges faced by mental health service providers. These challenges are even greater when the children served are deaf, and when staff members are expected to be multilingual, be knowledgeable about deaf culture, and be able to treat children with a multitude of severe mental health disturbances. Staff members face the dilemma of both raising and treating children in the same setting with limited resources. Limited funding and limited service models encourage the practice of hiring staff members with minimal skill requirements, at low-end pay rates, and with little support or training. This article (a) identifies the issues which threaten the delivery of quality treatment for deaf children with severe emotional and behavioral problems; (b) describes the process that changes well-meaning staff into casualties of their work, and (c) makes recommendations for mental health service administrators, supervisors and agencies to help create and strengthen their therapeutic system.

Introduction

Mental health professionals who work with deaf children often report that their experiences have a profound impact, not only on these children, but also on themselves. These professionals find themselves challenged emotionally, intellectually, and physically, and discover a new appreciation for the importance of compassion, humor, and energy in their work. Durkin (2002) compared this work to that of a dedicated anthropologist, requiring both an understanding of culture, and an interest in evaluating which social structures bring about successful and lasting adaptations.

Mental health professionals that work directly with deaf or hard- of-hearing children often fill dual roles of primary caretaker and therapeutic agent, a challenging and often stressful responsibility. These professionals must make children's needs their first priority while effectively managing their own needs and anxieties (Durkin, 2002; Braxton, 1995). The vast majority of mental health professionals filling these roles are not psychologists, social workers, or physicians; they are typically paraprofessionals with limited formal training, tempered with practical experience, commonly referred to as "staff'. The majority of therapeutic work is delivered daily by staff members in the child's natural environment, not periodically in a counselor's office, as many assume (Durkin, 2002; Wood & Long, 1990). Staff report high levels of commitment to these children, but this is not enough to prevent. staff from becoming overwhelmed and experiencing burnout (Decker, Bailey & Westergaard, 2002). Burnout among treatment staff is a widely known phenomenon (Decker Bailey & Westgaard, 2002; Braxton, 1995; Whitebook, Howes, & Phillips, 1989). The term "burnout" was first used by Herbert Freudenberger in 1977, and can be defined as a syndrome of

emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do people-work of some kind, often resulting in high rates of job turnover (Maslach, 1982). The concept has since been validated by substantial research (i.e., Decker et al., 2002; Thomsen, Soares, Molan, Dallender, & Arnetz, 1999; Manlove, 1993; Maslach, 1982). Braxton (1995) expanded the concept of burnout to include staff members feeling overwhelmed by their own unresolved childhood issues and boundaries when confronted with their clients' problem behaviors, especially in a working environment that provides little emotional support. Conservative estimates of the turnover rate of child care workers in residential treatment facilities are about 40 percent annually (Decker et al., 2002; Dietzel & Coursey, 1998; Manlove & Guzell, 1997; Onyett, Pillinger & Muijen, 1997; Whitebook Howes & Phillips., 1989). Such frequent changes in staffing can have significant negative impacts on clients and staff who are left behind, such as poor morale, increased workloads, and treatment regression (Reid, Johnson, Morant, Kuipers, Szrnukler, Thornicorfi, Bebbington & Prosser, 1999; Zunz, 1998; Whitebook, Howes, Darrah, & Friedman, 1981). Some studies have attempted to identify specific variables which correlate with general child care staff burnout (i.e., Muon, Barber, & Fritz, 1996; Manlove, 1993; Fant & Ross, 1979), but few have focused on staff members in residential settings, and none with deaf clients (i.e., Durkin, 2002; Decker et al., 2002; Braxton, 1995). Employers in child mental health treatment settings, long struggling with staff burnout and resultant turnover, have often blamed burnout on a poor staff commitment.

Special Treatment Needs of Deaf Children

Children with mental health problems often present with a long list of emotional and behavioral disorders, including poor emotional regulation, impulsivity, dissociation, withdrawal, depression, self- mutilation, and destructive behaviors. For deaf children with mental health problems, such problems are compounded by special communication needs and few available deaf supportive resources. Their complex mixture of emotional, behavioral, educational and communication support needs test the capabilities of staff members and the facilities that serve them.

Deaf children may perceive their treatment environment as either safe or dangerous. Which perception is supported depends on how staff members manage the treatment environment. Deaf children perceive their environment as dangerous or unsafe when staff members are unable to manage a child's problem behavior. Some children will react with a flight response, by running away or withdrawing. Others who see the environment as hostile will react aggressively with little provocation, fighting those they perceive as a threat. Other children will attempt to manipulate staff members to achieve safety, power, and control, sometimes by exaggerating their own needs or level of illness and drawing staff members into conflicts. This behavior is termed as "splitting".

These survival behaviors are often labeled as impulsive, maladaptive responses, stemming from some core characteristic of the deafness persona. In reality, these behaviors are exhibited by both hearing and deaf children with similar backgrounds and life circumstances. Additionally, when deaf children exhibit these survival skills, they are at a higher risk of being diagnosed with Borderline Personality Disorder.

It is not uncommon for hearing children to feel powerless because their entire lives depend largely on adults (Berk, 2004). In healthy child development, as children get older, they are given increased amounts of responsibility (Braxton, 1995). Parents gradually help

children mature by teaching internal control and self sufficiency. Deaf children are at a developmental and social disadvantage compared to their hearing peers, because deafness is often viewed as a medical problem that needs to be solved rather than a social problem that requires accommodation. This may intensify the experience of powerlessness. Deaf children living in treatment settings are likely to experience even more intense feelings of powerlessness, because of the rigid structure imposed by the therapeutic environment.

Other differences between the experiences of deaf and hearing children have an important impact on their mental health treatment. Deaf children experience a higher rate of physical, sexual and psychological abuse compared to their hearing peers (Vernon & Daigle-King, 1999), and deaf children in treatment settings experience even higher rates of abuse. Thus, deaf children in treatment settings are often disaffected, angry, and slow to trust any adult. These children will test staff member limits in order to determine if they can depend on and trust staff. It is important for staff members to be aware that these children will work to prove the staff members are not trustworthy, just like the other adults in their past. Staff will find it a difficult test to pass, even though these same deaf children beg in silence for the staff members not to give up (Braxton, 1995).

It is critical that staff members be aware of these children's motivations, monitor their own feelings, and moderate their actions. Staff members cannot rely on the deaf child's external behavior as an accurate representation of the child's inner condition. Staff members will need to be emotionally available despite the deaf child's inappropriate and intrusive behavior. At other times, staff will have to set limits for the deaf child, even in the face of children who are functioning as “walking wounded" (Braxton, 1995). Repeated experiences of disappointment with adults will evoke deaf children's aggressive behavior towards others, self-injurious behavior, uncontrollable rage, withdrawal, depression, and even suicidal behaviors.

Every wounded child experiences anger as a prominent emotion. This anger can be turned inward, to depression, withdrawal, or dissociative episodes, which are escape techniques to avoid overwhelming pain. Anger can also be turned outward, appearing as aggression and hostile assaults on the environment. It is important for staff members to be prepared to manage deaf children's anger and rage. Staff must learn that anger is the emotion of distancing and separation, often used for the purpose of pushing people away. For the wounded child, anger is fueled by past hurts and is aimed at punishing or hurting a peer or adult in their current environment. Anger is expressed by striking out, hitting, kicking, biting, scratching, gouging, head-butting, spitting, or inflammatory and primitive language (Braxton, 1995). Staff members are often unaware that beneath all forms of anger lay the catalyzing emotions of fear, pain, and vulnerability. Since the angry child is really a frightened, vulnerable, or hurting person, the anger is aimed at keeping people away from the true causation. Expressing or acknowledging the underlying pain and fear often feels dangerous, like giving up one's armor and defenses (Reich, 1972).

The very same armor and defense mechanisms can lead to distortions about love and relationships. What passes for love is often based on anxiety and hate in the armored person, since the natural flow of emotions is not permitted. Typical emotions are replaced by tension, pain, and constricting inner experience. In their attempt to protect themselves, these children experience love as controlling, holding on, and self-gratifying for the other person, rather than as healthier expressions of caring. Our wounded children have great difficulty opening up to love. This is one reason why they are good at "biting the hand that feeds them." They often do not know how to simply "take the hand" of a truly caring adult,

because this is a completely new inner experience for them, and they have to learn how to allow themselves to feel safe and trust again (Braxton, 1995).

Staff Support Needs

Staff members working with deaf children who have severe emotional and behavioral problems are expected to promote growth and provide treatment. Staff members are expected to know sign language, understand the deaf experience, and ensure that daily living tasks are managed. Paraprofessionals entering residential care work with disturbed children typically have an undergraduate degree at best, and little practical experience (Braxton, 1995). Such paraprofessionals are between 20 and 30 years old, the phase of adult development that involves searching for personal identity. Since undergraduate and graduate level educational institutions do little to encourage serious emotional growth, young adult staff members with little or no experience working with troubled children are likely to become casualties themselves (Braxton, 1995). Staff members are expected to take care of very difficult and complex children, and to stay emotionally healthy while doing it. Staff members are expected to rise above the child's limitations and problems. Staff members must manage, teach, discipline, and nurture the children in their care. These are high and unreasonable expectations for most professionals, and even more so for inexperienced paraprofessionals.

The responsibility of supporting staff and sharpening their therapeutic skills typically falls on treatment agency supervisors. Most often, agencies are delighted to find either a deaf or hearing staff person who can communicate using sign language; however, a potential staff member's maturity, knowledge, and therapeutic skills are often not assessed, and staff training needs are often neglected. The pressure on mental health service agencies to maintain programs despite limited resources is a key contributing factor to poor service quality and staff burnout, and budgetary restrictions make staff development a miscellaneous item in an agency's budget. The issues of staff training, preparation, and adequacy often move to the forefront reactively, when a crisis occurs. Crisis may take the form of a deaf child becoming physically ill, exhibiting serious psychiatric disturbance, running away, stealing, hurting other people, or damaging property. Frequent crises may result in high stress levels on the job, resulting in low morale and increased turnover.

Staff members who are expected to care for and treat deaf children with severe emotional and behavioral difficulties must be socially and emotionally mature. Having high grades or a college degree from a prestigious school does not guarantee adequate preparation for this work. Educated staff members tend to use clinical jargon to attribute problems on the deaf children, instead of assessing their own inadequacies. When staff members use clinical jargon and theories to deal with a deaf child in crisis, they are actually distancing themselves from the child by intellectualizing, as an avoidance technique. Over-reliance on clinical interpretations and emphasizing the pathology of children is a way for the staff members to insulate themselves from the children (Durkin 2002; Durkin, 1967).

Staff members need to be aware that depression, angry outbursts, withdrawal, impulsive behaviors, and dissociative episodes in deaf children are often the only way the children know to express their feelings. Unfortunately, common staff reactions include punishments, restriction of privileges, shaming, labeling, dismissing, or medicating the deaf. child. Staff responses often do not include planned clinical interventions designed to teach alternative or desirable skills or to help deaf children process existing problems. Because

the staff members have power and control, the pathology and problems are blamed on the deaf child, without looking at the emotional or skill needs of staff members.

Staff members are expected to help these children through a healing process, moving from pain, anxiety, and anger towards learning healthier, adaptive behaviors. Staff members are also expected to ignore or rise above emotions elicited by a child's crisis or problem behavior. In order for staff members to succeed as healers, they must have a set of inner resources to access. Minimally, staff must have developed those inner resources before they are expected to act as role models, to love, teach, discipline, and manage deaf children and prevent burnout. Staff members without the requisite experience, training, emotional maturity, and inner resources are at high risk for burnout.

Causes of Staff Burnout

A number of common predictors of staff burnout in mental health settings have been identified, including:

1. The work creates excessive emotional and psychological demands on the workers and staff, such as emotional exhaustion
2. Staff perceive their work as having little benefit for the clients
3. Staff develop negative attitudes, such as suspiciousness and superiority
4. A general lack of supervisory and co-worker support
5. Inadequate education and training
6. Inadequate salary
7. Generally poor working conditions (Decker et al., 2002).

Burnout can manifest in many different symptomatic forms, but a variety of physical, psychological, and emotional characteristics are common (Aronson, 1987; Freudenberger, 1974). Physical characteristics include feelings of exhaustion and fatigue, an inability to get rid of lingering colds, headaches, development of stomach problems, insomnia, shortness of breath, skin irritations, and general aches and pains. Psychological and emotional characteristics include touchiness and irritability, crying easily, being quick to respond, increased sadness, lack of motivation, outbursts of screaming and shouting, inability to show caring actions, and general lethargy.

Burnout is common in the helping professions, and it affects all professionals who have a strong commitment to helping others. Professionals experiencing burnout may eventually lose their ability and desire to care for others. Burnout can demoralize a caring and compassionate individual, and as a result, that person can become a cold, callous professional. As caregivers begin to burn out, they may not recognize what is happening to them. Burnout is a slow, unrestricted feeling that begins inwardly. Over time, caregivers lose the desire to control their feelings of helplessness and inadequacy.

Braxton (1995) explains staff burnout from the psychodynamic perspective. The foundation of his explanation is the staff's ego development and staff need for safety and a holding environment. Maslach (1982) suggested that burnout is a physical, mental,' and emotional reaction to the chronic, everyday stress that results from social interactions. Decker et al. (2002) notes that almost all research on burnout and child care workers has emphasized either an internal defect of the staff member or a social learning problem, resulting in either implicit or explicit alienation (Seeman, 1959).

The process of alienation involves the interplay between an individual and the institutions of his/her society, and how that individual acquires his/her legitimate identity within society. According to Seeman (1959), there are four key elements in acquiring a legitimate identity within a social order at work: competence, usefulness, belonging, and power. One's sense of competence, usefulness, belonging, and power does not come from within but rather from role performance in the social world, and in particular institutions within that social world. Alienation results when an individual feels society has not given him/her adequate feelings of competence, usefulness, belonging, or power in exchange for role performance.

Staff members working in treatment settings often feel undervalued, struggling to establish the importance of their roles to administrators and supervisors who treat them as people of lesser status or subordinates. The fear of alienation is a strong, defeating sense experienced by many staff members on the verge of burnout (Decker et al., 2002). Staff members can experience role estrangement - that their primary role is one of baby-sitter and little else. In addition, staff members feel culturally estranged when their supervisors and co-workers do not validate or show respect for staff member values, attitudes, and behaviors. Staff members who are alienated also feel a sense of meaningless, and want more freedom and responsibility to development legitimate identities within the treatment center and structure. Staff members also feel they lack guidance and support; although they have legitimate professional needs and desires, they do not see any way to fulfill these within the present work structure.

Dynamics of Deaf Children and Staff

A deeper understanding of how staff members and the deaf children in their care interact can be useful to understanding what conditions are necessary for effective treatment delivery. A basic appreciation for transference, counter-transference, and fear and alienation can help staff members develop critical insight into their roles as treatment providers.

When attacked by a child, inadequately prepared staff may not know how to differentiate between their own intense feelings and those of the child, and staff members are likely to take the child's behavior personally. Once the attack is personalized, the therapeutic boundary between the child's issues and the staff's issues is quickly lost and it is only a short step to projecting intent into the child's behavior. Transference may 9ccur when the child treats staff as if they are authority figures from their past (Braxton, 1995).

Counter-transference may occur when staff behave as if they are those past authority figures. Staff members may react as if they have no power or objective authority to deal with the child. Frightened staff are mirrors of the hidden fear in their angry clients, and many programs are not structured to address this problem. It easier to ignore staff concerns and allow them to distort issues when there is no structured, safe, therapeutic environment that will help them to work out their own pain (Braxton, 1995).

In the absence of appropriate structure, many front-line treatment staff members, especially in residential programs, become covertly or overtly abusive. Staff abusiveness, if ignored when it occurs, will have long range consequences. Eventually, these abuses of power cause enough acting out behavior on the part of children to produce a crisis of some sort. The crisis, if examined carefully, has both the child's and the staff member's issues contained in it. It is entirely too easy for staff to unconsciously provoke children to act out, and then blame and punish them for doing so. When staff are frightened and have no place

to get help and support, they lose control of themselves first, and the children they work with next (Braxton, 1995).

Right next to the child's anger is the staff member's fear of the angry child and fear of alienation by his/her treatment team, which mirrors the child's fear of abandonment by the staff (Braxton, 1995; Seeman, 1959). Frightened staff create an atmosphere that feeds the sense of things being out of control. Fear cripples staff and immobilizes their energy. Frightened staff cannot trust themselves to act on behalf of the child, so they hold themselves back. Disturbed children often recognize the staff's limitations and exploit them. Children hate the staff for not being emotionally available for them, but they also seem compelled to exploit the staff's weaknesses in order to get control of an anxiety-producing situation.

Fear and fear of alienation rob staff members of the use of their observing egos. Few people are interested in understanding what is going on when they are frightened. When staff cannot stop and ask themselves what is happening and why, they are usually caught' in a survival struggle, from which they cannot extract the meaning or the message in the child's behavior. As a result, they lose an important therapeutic boundary, and the treatment environment becomes even less able to help the child make choices (Braxton, 1995).

Fear and anxiety of potential alienation cause staff to engage in survival and control tactics rather than therapeutic interventions. Frightened and anxious staff members will not risk giving a child enough space to solve a problem, either with their help or alone. They crowd the child because of their own fears that things will get out of control, and they create win/lose situations, which are actually losing situations for both staff and child. When the disturbed child has no room to make choices, or is faced with ultimatums and "no way out" power plays, too often they will choose self-destructive alternatives (Braxton, 1995).

Fear and perception of alienation causes a split in feeling and thinking. Frightened staff members either become intellectual and lose contact with the child, or they become emotional and cannot think about the meaning of what is happening (Braxton, 1995). Both positions put staff at a disadvantage with troubled children, whose experience with adults is largely that of being disconnected from them or attacked by them, and not being able to find a whole person when they most need one.

Frightened staff members are often irrational, erratic, and uncentered. Even if a frightened staff member covers her or his own fear, the fear will not disappear until they learn how to manage it. Being frightened, anxious, or angry with a child is not a problem if adults acknowledge the reality of their own feelings and needs. The feelings themselves are not the problem; it is what the staff do with their feelings that is important. Staff need help in understanding what it is they are feeling and why. When they do not get that help, the children become victimized by unresolved staff issues (Braxton, 1995).

Durkin (2002) and Braxton (1995) suggest that forma structures should be provided for staff members to be able to continuously find and retain their objectivity and their separateness from the child Maintaining a therapeutic stance in a treatment setting with children and adolescents involves recognizing that therapy is not an event, but a process. Therefore, being a therapeutic agent requires an environment with structures that are organized around the specific but different needs of children and staff. These structures offer a framework that allow the therapeutic process to unfold over time, with safeguards for both staff and children. Offering therapy means creating conditions for change (Braxton, 1995). Change, if it is therapeutic change, means growth; and growth involves conflict, pain, pleasure, turmoil, and fear. In an effective treatment program, facilitating the change

process eventually leads to separation, individuation, and growth. Our wounded children will only risk opening themselves to these emotions and struggles if the agency provides an adequate "holding environment" for them. This can only be accomplished if there is an adequate holding environment for staff.

Solutions

The authors of this article were involved in the development of therapeutic residential, educational, and community services for deaf children with severe emotional and behavior problems. These services emphasized the Re-Education philosophy developed by Hobb (1982), and the philosophy of Holding Environment, developed by Braxton (1995). There are three categories of recommendations: 1) How to select and hire new staff; 2) How to create a therapeutic-holding environment; 3) How to strengthen a therapeutic system.

Selecting and Hiring Staff

Evaluating sign language skills, screening resumes, and using standard interview questions may not help much as managers screen for appropriate staff members to work with wounded and challenging deaf children. Staff members need to be screened for their own childhood developmental experiences. There is a strong correlation between doing effective work with children and having successfully worked through the problems of one's own childhood (Braxton, 1995). Many staff members work through their own unresolved childhood problems when confronted by the problems of deaf children they are serving. Staff members who have not resolved their own childhood conflicts will not be open to helping others work through their own conflicts, or may unintentionally impede the resolution of problems.

It is crucial to determine how potential staff members manage anger. Anger can be a healthy emotion when people are able to manage it, have a healthy outlet to express it, and do not become frightened by its intensity (Braxton, 1995). Anger has a counter-part and a counter- balance, which is the potential for intimacy or closeness. Wounded children often experience anger as their primary feeling. They have learned to use anger as a means to defend against closeness because it brings feelings of vulnerability. Many children have been mismanaged due to staff inability to manage the children's and their own anger. Table 1 is a list of sample questions that interviewers can use to help screen potential staff members (Braxton, 1995).

Table 1. Sample Interview Questions for Screening Treatment Staff

Area	Interview Questions
Strengths and Needs	▪ How willing is the staff member to look at his/her own personal limitations, weaknesses, and liabilities, as well as strengths, resources, and assets?
Feelings	▪ Can the staff member acknowledge and/or express feelings such as anger: sadness, caring, and affection? ▪ Does he or she understand when, how, and to whom these emotions can appropriately be expressed? ▪ How was anger expressed in his/her family of origin, and how does the staff member express it?

	▪ How does the staff member behave when he/she is sad? ▪ How does the staff member show others that he/she cares about them?
Authority	▪ What problems does this person have with authority? ▪ What was the staff member's relationship with his/her parents during adolescence? ▪ When the staff member had a disagreement with his/her parents, how did she/he exhibit those feelings?
Intimacy	▪ What is the staff member's capacity for intimacy? ▪ Does the staff member have existing, intact, intimate relationships?
Differentiation	▪ How well did the staff member manage differentiation from his/her family of origin? ▪ Who does the staff member depend upon when there is a crisis or problem in his/her life? ▪ How has the staff member made important life decisions?

Managers in charge of hiring must be able to identify the experiences and resources needed by staff, or they will be short-changing the children and adolescents whose emotional healing processes have been placed in their hands.

Creating a Therapeutic-Holding Environment

Psychoanalytic literature describes the concept of a "holding environment" as a metaphor for the security of the infant being held by the mother (Weiss, 1971). The Re-Education literature describes the concept of "trusted adults" in creating an environment for children to make mistakes and learn unconditionally (Hobbs, 1982). These two concepts together describe a therapeutic environment that must meet the criterion of safety, without which the disturbed or anxiety-filled person will not risk rectifying his/her condition (Weiss, 1971). Braxton (1995) suggests that safety and security must exist in order for wounded children to risk opening up their wounds to themselves or to others. The agency is responsible for the creation of this requisite condition. Since an agency's management is responsible for overseeing the quality of the staff and their work with the children, management must provide an adequate holding environment for the staff in order for staff to create one for the children.

Braxton (1995) described three conditions that are required to create an adequate holding environment for children and staff in treatment settings. First, staff members need opportunities to come together and express their experiences of frustration and anger with both the children with whom they are working, and with the administration to whom they are responsible. Staff members need a regular emotional catharsis because of the impact of working with wounded children and the heavy responsibility imparted to them by authority figures. Staff members need to be free to say and express whatever is bothering them - no matter how critical, ugly, violent, or destructive it may be. Only after there is genuine

freedom to express such feelings can the staff move to the next phase of a therapeutic-holding environment.

Second, staff members need to find meaning in their treatment experiences. What do their emotions tell themselves about the problems they are facing? What understanding can they develop by exploring their own behavior and that of the children to whom they provide services? When supporting staff members use self exploration in a structured way it can be a valuable experience. Using consultants or external training opportunities can enable the staff to look at the issues that may be influencing them.

Third, an adequate therapeutic-holding environment has a common, communal component, such as regular staff and peer group meetings that encourage discussion about ongoing issues occurring in the treatment setting. This is an opportunity to help individuals connect current experiences with past events, thereby gaining insight into their own behavior. .

A number of conditions can interfere with the development of effective holding environments. Abandonment and intrusiveness are antithetical to holding environments (Modell, 1976). Either of these conditions will produce fragmented and disintegrated systems. Thus, a goal for agency management in providing a good therapeutic-holding environment for staff is to offer support and active listening without being intrusive. Staff members need a structure to talk openly with each other about the feelings children create in them without feeling judged for having those feelings. In turn, staff, in turn, will be less likely to ignore or intrude on the children who need some of the same things from them. When children's privacy or personal space is invaded, or when frightened staff cannot maintain a therapeutic perspective, the children tend to lose their boundaries and express themselves in angry episodes, temper tantrums, or limit-testing. Unless adult caregivers can help children take more responsibility for their behavior and hold them more accountable, their behavior will become increasingly more difficult to contain. Children and adolescents will not feel safe or secure enough to move past their anger and to openly reveal their more vulnerable, inner selves. Without an adequate holding environment, they will not risk change (Braxton, 1995).

Depressive conditions and the fear of total indifference from others can also interfere with the development of a therapeutic-holding environment. A depressive condition may occur when people in the environment do not pay any attention to the emotional needs of the individual and do not take the time to validate their attempts to express themselves. A person experiencing a depressive condition may be thinking, "If I express what I really feel inside, no one will be there to support me" (Braxton, 1995).

Paranoid conditions represent the fear of retaliation. This may occur when people attack or criticize staff or children for having the feelings they have, or for daring to express them. When the expression of a feeling is treated like a violation or attack by others, self-ventilation is avoided as a dangerous activity (i.e., "I'll lose my job" or "Staff will hate me"; Braxton, 1995). A person experiencing a paranoid condition may be thinking, “What will someone do to me if I say what I really feel?"

Depressive and paranoid conditions are related to both client and staff peer groups. Both conditions arise from a perceived scarcity of care-taking resources (safety, love, acceptance, shelter, kindness, warmth, altruistic caring, tolerance for human faults and failings, and ability to "be with" others in pain) in the larger group system (Braxton, 1995). When these conditions exist, children and/or staff begin competing for what is perceived as a scarce commodity.

It is difficult to correct problems within the therapeutic-holding environment unless staff members are willing to be confronted about their roles. An adequate therapeutic-holding environment requires staff to be available to the child when needed, but not to be intrusive or abandon the child. When children become unresponsive, closed down emotionally, or impotently accommodating, it can be attributed as much to a flawed holding environment as to the individual's pathology or developmental issues. Training staff to manage their own anxieties, to work out their fears, and to develop the requisite intervention skills to genuinely help troubled children requires specific training. Agencies often err by failing to budget for adequate staff training and development. This results in greater child and staff turnover.

Strengthening a Therapeutic System

Prolonged and intimate relationships with troubled children are threatening to staff members. Durkin (2002) stated "children, of necessity, attack where the tyrants are weak." When we do not choose staff carefully, the adults we select are often unequipped to manage the children with whom they are charged. The disturbed child frightens staff members because staff members' own unresolved conflicts are triggered by the child When staff members provide services without the ability to identify what their own feelings are, staff members cannot readily distinguish between their own issues and those of the children they encounter. Braxton (1995) provides a number of staff member and agency development strategies that can be used to strengthen the therapeutic quality or responsiveness of any treatment system:

1. Use clinical consultation at the administrative level to help both management and the larger organization see broader systems issues, and to carefully determine whether the structures being used are adequate for the tasks being tackled. These include effective problem solving structures that encourage managers to move beyond the limitation of their individual perceptions, and collaborate to examine and resolve systemic and work-group problems.

2. Create a support system, which includes adequate clinical supervision for staff members providing direct service to the client population. Staff members also need opportunities to share. their individual experiences about working with the children and other staff. They need a confidential, private place to take their own wounds and pains when they are opened up by contact with the wounded child, or by their rivalry and competitive impulses with other staff members. The need to appear in control by minimizing conflicts and issues that interfere with the adequate "holding environment " Therefore, each staff member needs a place where the emotions generated by the work with troubled children can be safely aired and understood. That understanding can then be utilized for taking responsible action.

3. Develop a training plan that emphasizes the strengthening of the psychological and emotional capacities of staff, and then focus on building skill levels and knowledge. The latter is meaningless without the former. No matter how much knowledge staff members have, they will remain highly vulnerable to the emotional pull of troubled children (counter-transference) when there is

insufficient attention given to maintaining their emotional development. Moreover, the training must be an ongoing, interconnected process, not a series of hit-or-miss events.

4. Develop a training program that is ongoing, comprehensive and competency-based, rather than information-based. Competency takes more time to develop, but deepens staff members' abilities and commitment to the work. It focuses on understanding the roots of behavior problems and the skills necessary to get results.

5. Require that every staff member be well educated in child and adolescent development. There is no substitute for this knowledge. Its absence is the source of some of the most destructive staff behaviors. A solid grounding in research concerning therapeutic treatment of disturbed children is also necessary for effective functioning on the part of staff.

6. Provide training for supervisors and middle management personnel. Supervisors need to maintain and continually upgrade their clinical skills in order to maintain and improve the quality of the overall treatment environment.

Conclusion

In his latest article reflecting on fifty years of work with children. Durkin (2002) eloquently summarizes the existing reason for improving support for mental health paraprofessionals who work with deaf children:

"Michelangelo said that he did not carve men out of blocks of stone but uncovered them in it. I liken this to the process of promoting normal growth and development and helping to heal hurt children. Child care is a wonderful and noble profession that can give full meaning to the concept of agape and allows its practitioners to lead fully inhabited lives."

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