

Meeting the Challenge: Treating Diverse and Difficult Problems in Therapeutic Foster Families

D. A. Burge
Bernard D. Fabry
Richard L. Conaway
Jo James

The Pressley Ridge Schools
530 Marshall Avenue, Pittsburgh, PA 15214

This article appeared in the American Psychological Association's newsletter, The *APA Monitor*, in September, 1987, as a result of a presentation at the meeting of the American Psychological Association in New York in August, 1987, on treating dually diagnosed children in family-based settings. Three exemplary cases are presented.

The current challenge to foster family-based treatment programs is to extend service delivery to children with diverse and unique behavior problems. Child care institutions, residential treatment facilities, and to some extent, group homes design and implement their programs for relatively homogeneous populations or arrange subgroups of youths whose problems are similar. As a result, it is programmatically difficult to treat children with unusual combinations of problems. The foster family-based treatment model is a viable alternative to meeting this challenge. It can be highly responsive to the individual child's unique constellation of skill and performance deficits. In addition to the overall benefits of foster family-based treatment (e.g., treatment cost, high staff to child ratio, consistency of treatment performance across staff), there are other more compelling reasons to consider treating a wide diversity of seriously disturbing child behaviors within foster family-based treatment settings:

1. preventing increasingly restrictive treatment environments for children who, because of the severity of their behaviors, either do not clinically fit in to other treatment alternatives or have not benefitted from their stay in previous programs.
2. empirically demonstrating the efficacy of foster family-based treatment programs with particularly difficult and different types of child behavior.
3. identifying and analyzing program failures so that the existing program limitations can be defined and modified to increase the probability of success with yet more children.

The foster family-based treatment programs of the Pressley Ridge Schools represent viable alternatives for extremely difficult-to-treat children who display seriously divergent problems. Because children are treated individually within the context of separate families and local communities, the program avoids some of the limitations inherent in treating children in group residential settings. In Pressley Ridge's family-based treatment programs, parents are trained to function as highly-skilled treatment agents by using a variety of therapeutic teaching, motivational, and relationship-building skills. The professional treatment parents are required to document their daily use of these skills according to an individualized treatment plan developed by a professional staff. Supervision and in-home training are conducted during frequent visits to the homes by the parent supervisor, who also provides 24 hour on-call services to parents.

Since the programs started in 1980, the Pressley Ridge family-based treatment programs have served over 275 children from 3 to 18 years of age with a wide variety of presenting problems and have a better than 70% success rate of discharging children to less restrictive settings. To illustrate how family-based treatment can be highly individualized for each child, three children with very different presenting problems are presented.

Case 1

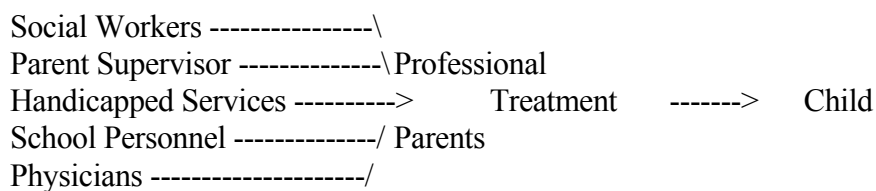
Wendy is a 6 year-old white female who is multiply-diagnosed as suffering from Spastic Cerebral Palsy, profound mental retardation, epileptic seizures, near total blindness due to marked optical atrophy, and microcephaly. These physical and intellectual disabilities are the primary result of a prenatal cytomegaloviral infection, a medical entity which is relatively rare in the U.S. population. The average incidence of CMV infection is 1% of all live births, and it is estimated that

only 5 to 10 percent of those infected have the more virulent form which leads to such extensive impairment.

Wendy was placed in an emergency shelter foster home when she was 2.7 years old. She had been removed from her biological family because of severe neglect; her biological mother routinely fed her only once per day because of the difficulty and time involved in getting Wendy to keep food in her mouth and swallow. Necessary medical and physical therapy appointments were not kept and Wendy's seizure disorder remained uncontrolled. Her biological father left the home soon after Wendy's birth. Her mother was charged with neglect and all parental rights were subsequently terminated. The foster couple who cared for Wendy during the next 2 years had become extremely frustrated with her developmental progress and dissatisfied with the degree of technical support available to them. The social worker involved with this family referred Wendy and her foster family to Pressley Ridge to prevent Wendy from being moved to the only other viable placement option-- an overcrowded state residential facility for the developmentally delayed. After receiving training to be certified as professional treatment parents, Wendy continued to live with her foster parents through the Pressley Ridge program.

When Pressley Ridge staff began working with this foster family, Wendy's average level of developmental functioning across all areas was 1.5. She did not initiate or maintain a sitting posture, ate only pureed baby foods and drank fluids from a bottle, exhibited a poor swallowing reflex which caused frequent gagging and vomiting of food, engaged in frequent self-abusive and self-stimulatory behaviors (e.g., finger biting which resulted in bleeding and scarring, head banging, abrading skin on her feet and chin by repeatedly rubbing across textured surfaces, mouthing objects). Physically, she was markedly underweight, experienced daily seizures, had frequent ear infections, and suffered from nearly continuous respiratory infections.

A major feature of Wendy's treatment plan has been the development, integration, and coordination of many clinical consultations and specialized diagnostic services. In order to obtain needed collateral treatment services for Wendy, it was imperative that her treatment parents be well-trained in the use of professional services. It was due to this in-home skill teaching that the treatment parents were able to utilize information and recommendations from child care professionals to enhance their direct treatment with Wendy. The following diagram exemplifies the flow of services to this child within the Pressley Ridge model of family-based treatment:



Because of the extent of Wendy's physical and intellectual limitations, it was necessary to develop a uniquely individualized motivation system that cued the treatment parents to engage in the numerous therapeutic activities and procedures across the day, many of which were scheduled across specific times of the day. In addition to completing their documentation of parenting skills on a daily basis, the treatment parents collected and maintained detailed data on Wendy's performance during training trials and assisted in graphical analyses of these data to guide treatment planning and

implementation.

Wendy's current levels of functioning, assessed by standardized measures of infant development, are at 4 months for expressive language, 3 months for fine motor skills, and 2 months for gross motor skills. She eats solid food, drinks from a cup, produces monosyllabic sounds in response to verbal stimuli, sleeps 6 to 8 hours per night without screaming or crying, expresses pleasure when she is held or touched, and has shown a large decrease in her rate of self-abusive behaviors. Wendy rides a schoolbus to attend a special education class twice per week, and will be attending school 5 days per week this Fall. Her treatment parents report that they are pleased with Wendy's progress, the efficacy of the skills they have learned, and with the technical and emotional support that the program staff provide. Wendy's teachers and social worker also report noted improvement in the treatment parents, stating that they seem quite confident now and are more optimistic about helping Wendy function in spite of her disabilities.

Case 2

David is an 18 year old black male who was referred to Pressley Ridge at the age of 14. He is the third of four siblings and was born four-weeks prematurely. At age two, the couch on which he was sleeping while at home caught fire resulting in severe scarring on his face, scalp, and one arm. Plastic surgeons advised that attempts at cosmetic improvement should not be considered until David was at least age 17. Soon after this incident, David's father left home and his unemployed mother developed a chronic alcohol addiction. David was neglected by his mother and rejected by other adults and children in his neighborhood. His first documented contact with mental health services occurred when he was six and his mother was found intoxicated. At age eight, he was removed from his mother's custody because of alcohol intoxication and neglect, but was returned home. At age ten he was placed in an emergency shelter after apparently burning down a vacant apartment building. At that time, it was reported that David had been noncompliant and aggressive for several years, had many attempts at running away from his home, refused to attend school, destroyed property and shoplifted, and exhibited nocturnal enuresis.

During his time at the shelter, David was evaluated and diagnosed as physically handicapped with a hearing loss, intellectually functioning in the mild mental retardation range, and emotionally disturbed. Following a two-month inpatient psychiatric evaluation, David was placed in a residential treatment program for three years. During that time, he received diagnoses of anxiety reaction of childhood with psychotic behavior, secondary to possible mixed organic brain syndrome; chronic depression; conduct disorder of childhood, undersocialized, aggressive type; borderline intelligence, with full scale IQ scores ranging from 64 to 76; and school and family dysfunction. When referred to Pressley Ridge, his behavior was described as psychotic, erratic, and bizarre. He talked to himself in different voices, "became" objects, and always wore multiple layers of clothing to cover his scars. David slept in all of his daytime clothing as well, which consisted of full-length pants and shirts, gloves, a hat, and at least one coat regardless of the season.

Of the 37 problem behaviors observed and targeted for behavioral intervention following David's placement with his treatment family, the following is a sample listing:

Inappropriate verbal behavior -- talking to himself in different voices in public; reporting that he heard voices of other people in his head; communicating by nonvocal gestures only;

aggressive and threatening speech; expressing rigid antisocial beliefs contrary to physical evidence; stating that he was an inanimate object when stressed.

Inappropriate social interactions -- destruction of property; physical aggression towards children in the absence of adults; poor social skills with peers; avoidance of leisure or recreational activities; responding aggressively when receiving criticism or negative feedback; expressing sexual interest in very young girls; frequently interrupting the interactions of others to gain attention.

Inappropriate emotional responses -- flat affect; devoid of humor; refusal to allow others to touch him; difficulty differentiating between reality and fantasy; overly anxious and fearful; denial of any feelings; refusal to share or give gifts to others; demanding excessively structured routines.

Inappropriate other behavior -- refusal to wear new clothing; wearing multiple layers of clothes regardless of season; refusal to spend money; frequent nightmares; self-induced vomiting after meals; expressing confusion of his own racial identity.

In treating David's unusual combination of problems, various interventions and procedures were implemented by his treatment family in their efforts to obtain the desired behavior change. It was often the case that the logical and usual procedures used to change David's behavior were ineffective or occasionally caused an escalation of undesirable behaviors. An example of the highly individualized treatment planning that was necessary with David is the dramatic change in a target behavior which resulted from a planned ignoring procedure used by all of the treatment family members. Previous attempts to use skill teaching, time out, various communication techniques, intermittent reinforcement of alternative behaviors, and restriction of privileges had failed to have any effect.

Teaching alternative ways of behaving was an essential part of David's treatment because he had previously learned to avoid or escape from many situations which routinely confronted him. The successful teaching of appropriate verbal responses was made possible by the careful monitoring of daily progress and the individual attention of his treatment parents. An important outcome of their teaching was David's accurate labeling of his feelings and those of others. Effective use of the motivation system allowed David's environment to strengthen his newly learned skills and to promote transfer of those skills to novel settings.

David is now in the process of successfully completing a vocational and educational program at a local community college, and has received over eight different job offers. He has undergone two separate operations which totaled 29 hours of plastic surgery. He now appears comfortable with his appearance and no longer "hides" behind multiple layers of clothing. One year after his return home to his biological mother David maintains contact with his former treatment parents through telephone calls and weekend visits each month. Even though these follow-up contacts are not part of a formal treatment plan, David's continuing relationship with his former treatment family is due to their shared history of therapeutic interactions.

Case 3

Mary is an 11.9 year-old white female who was referred to Pressley Ridge at age 11. Mary is eldest of three children; her brother is currently living in a foster home and her sister is living in another Pressley Ridge professional treatment home. Mary's father is currently serving a 20-year jail term for child sexual abuse. Her mother, allegedly a prostitute, is serving a 6 to 9 month jail term for reckless endangerment and child neglect, both related to the father's abuse charges. Evidence of serious emotional disturbance and familial disruption is also present in the extended family. Mary's maternal Grandmother and Uncle committed suicide and her maternal Aunt has nine children who are all placed outside the home.

The first contact of Mary's family with mental health services occurred when she was nearly four years old. She and her brother were removed from their parents and placed in foster homes for 15 months because of parental neglect. Four years later, all of the children were removed from their home due to a combination of neglect, physical abuse, and sexual abuse. The children were punished by their parents by being tied up, locked in closets, or locked in the basement for days at a time. They were beaten with sticks and belts, and have scars which resulted from parent-inflicted burns. It was reported that all of the children were sexually abused by their father on repeated occasions. Sexual abuse also was perpetrated by a family friend who often babysat, and is now serving a 5-year jail term for abuse. The children were apparently abused in view of each other, with adults watching and taking photographs, and were reportedly forced to participate in intercourse with animals.

At age 9.5, Mary was placed in an emergency shelter and was so disruptive while there that she was hospitalized in a program for multiply-handicapped children. Following two months of treatment, she was placed in a residential program for seriously-disturbed children. During this time, she was interviewed by a program that specialized in treating young sexual abuse victims, but was rejected because there were too many complicating problems which mitigated against a successful treatment outcome. After 14 months, Mary was admitted to a psychiatric hospital for evaluation and then admitted to a state hospital for long-term placement. It was at this point that Pressley Ridge offered to treat Mary in a one of its professional treatment homes.

At the time of placement, Mary academically functioned at a kindergarten level and exhibited severe language delays as well. She displayed a wide range of intensively aggressive behaviors towards both adults and peers, including throwing objects, biting, hitting, kicking, scratching, and hair pulling.

With much teaching and emotional support, Mary and her sister have started to develop a healthy sibling relationship to replace their previous roles as parent and child. Socially, her conversational skills are greatly improved, her social competency with peers is better, and she is participating in more group activities. She can now play simple games with other children and has joined a softball team. The progress Mary has made to date is modest and has been slow, but it is taking place and it is occurring within a normal family setting instead of inside a custodial state institution.

In conclusion, the children presented have very divergent problems which required very different treatment approaches. They also shared at least five things in common. First, each child

benefitted from a high staff to client ratio within their therapeutic environments, with two or more treatment agents (parents) per child. Second, the stability and continuity of the professional treatment parents remained fairly high across time. Third, the treatment parents had continuous access to a team of professional staff who advocated for the children within the community, and were diligent in gaining access to many resources at local and state levels. Fourth, frequent communication and a high degree of intra- and inter-treatment agent consistency across the treatment parents and supervisory staff was maintained. And fifth, a treatment environment which was highly flexible and able to respond promptly to the clinical needs of the individual child was present in the form of individual families trained to meet the specific needs of each child. The Pressley Ridge family-based treatment programs believe that these features are essential components of an effective treatment alternative to the institutionalization of children who are extremely difficult to treat. Further, the program maintains a strong conviction that foster family-based treatment model of treatment holds much promise for expanding the presently limited treatment options for extremely troubled children in minimally-restrictive settings.

- - - - -