Treatment of the Violent Incorrigible Adolescent

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To my beloved kids—at home and at work

Preface

This book is designed for youth workers and those who intend to be youth workers. The term *youth workers* is deliberately vague, since this career is chosen by people of extremely varied backgrounds, experience, and education, and so it should be. The job is too significant to our society's future to allow one category of professional or paraprofessional to be labeled as the experts and the rest as the followers. This book is for those who face daily the enormous problems of extremely disturbed youths. This includes those working in mental health, youth corrections, social services, education, law enforcement, etc. This does not mean that anyone can be a youth worker. In fact, it is the author's opinion that the percentage of potential human services workers who have the abilities and skills necessary to work successfully with troubled youth is small. Chapters 5 and 6 discuss some of the personality characteristics necessary for quality performance.

The book is mainly devoted to the institutional treatment of the violent and resistive youth, termed the *aversive treatment evader* in this book. Some of the principles are applicable to all youth and to community treatment. However, the emphasis is on planning and carrying out institutional programs that will effectively intervene in the misery that these youths cause both for themselves and for others. Hopefully, it will also serve as an emphatic disagreement to those who say that treatment of juveniles does not work–that we should once again resort to handling them as smaller versions of adult criminals–neglecting to try to reach their emotional problems. It should also serve as a message to youth workers who have felt themselves constantly battered by faddish storms, while trying to persevere in the daily treatment of these youth. During the ten years the author has worked with youth, it seems there is a new answer every year that will solve the problem of our disturbed youth. When a highly favored new approach does not result in a prompt change in the existing problems, it is often rejected, or in some cases the approach is completely reversed. The treatment versus custodial care controversy is an example of the pendulum swings that occur as people search desperately for an answer to why juveniles are becoming increasingly violent and out of control. Because of high public interest in the problem, many people who have little or no knowledge or experience in the field offer (or force) their solutions to the problems. Although many academic, legal and political "experts" tell the typical youth worker what to do, the author feels that most have neglected the real source of expertise–the people who do the job. It is obvious that the state of the art of treating disturbed youth is in its infancy–but we are learning by doing. What is needed for the field to grow in effectiveness is more sharing of those techniques that have worked for people who have used them on a daily basis. This book is an attempt to do that sharing.

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In the new and difficult field of treating violent youth, it is a vital necessity to share concerns, techniques, and ideas. The list of those who have shared with the author is endless. In an attempt to cite those who have contributed most heavily, the author would like to thank:

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Kathleen Hannan, who died young, but not before she brought a special kind of beauty to the youth she worked with and to her fellow staff.

Perhaps most significant in the creation of this book were the many adolescents who touched the author's life over the past ten years. The most was learned from them, and they always gave as much as they received. Their names and details of their case histories are changed in the text, but the messages from their damaged lives are clear.

Finally, to my husband Jerry Agee, I am the most indebted for building up my store of love and support so much that it could be shared with youth who needed it desperately.

Contents

1 The Etiology of the Aversive Treatment Evader

Within the population of disturbed youth there is a growing percentage of youth who, as a group, cause more problems than all other adolescents combined. These are the youths that combine hostile, aggressive, acting out behaviors with an amazing resistance to change, usually to the point that some frustrated treater terms them "incorrigible" or "untreatable." Compared to other problem adolescents, they engender a totally disproportionate cost in money, time, and effort to those agencies charged with educating, apprehending, and treating them. They hurt, and occasionally kill, people. They steal and/or destroy a great deal of property, and they repeatedly harm themselves. At the very least, they are extremely disruptive to the people they are around–in their homes, in schools, in placements, and in institutions. Schools and social agencies exert much effort trying to meet their needs, police occupy much of their time trying to apprehend them, and the legal system spends enormous amounts of money in prosecuting them. Further, there are high costs to social agencies for treatment attempts and placements in a variety of institutions and placements. In addition, the majority of these youths graduate into the adult institutional system, where they continue to be a significant drain on society's resources all their lives.

It is as difficult to label this group of youths as it is to treat them. They cross not only all psychiatric diagnostic categories but also the various differential diagnostic systems. The only commonality of diagnoses is that they usually fall in the "severe" end of each diagnostic continuum. The psychotic and neurotic disorders are less often diagnosed in this population, but the character and personality disorders are well represented.

Because of the difficulty in psychiatric diagnoses, in this book, *aversive treatment evader* has been coined as a descriptive term for the typical behaviors of this group of youths. The term *aversive* refers to the effect these youths have on the people with whom they interact. Their habitual aggressive and often violent behavior makes most people attempt to avoid them. *Treatment evaders*, of course, refers to their ability to sabotage or resist attempts at intervention.

Following is a representative case history of an aversive treatment evader (ATE). It is obvious that there is no typical ATE. The following case history is cited to show the early onset of difficulties and a typical pathway through the system.

Tony. *Tony and his brother were abandoned by their parents when Tony was two and his brother was four. No one knew what happened prior to that time,*

only that the parents were transients. The boys were placed together in a foster home, where they stayed until Tony's brother was seven and was adopted by another family. Tony has never seen him since. At that time, Tony began showing problems of hyperactivity, immaturity, and distractibility. As soon as he entered school, he was reported to be disruptive and quite assaultive with the other children. When the social agency that had custody was notified, they decided to move him to another foster home.

At age seven, Tony was sent to another foster home where he would remain the longest time. Unfortunately, the foster parents immediately began to see problems. He started developing effeminate behaviors and a liking to play in girls' clothes. He also increased his assaultiveness, and particularly attacked little girls. At one time he was discovered choking a little neighbor girl, and at another time he was caught choking a dog. In school, Tony was in a special program for behavior-problemed children, but he was becoming increasingly worse. His nemesis was peer relationships, as he was thoroughly disliked because of his aggressive "tough guy" facade, his immaturity, and his homely appearance. He also began running away from the foster home because "no one loved him."

At age twelve, Tony refused to go back to the foster home after one of his runaways, and they, in turn, refused to have him back. Tony was sent to his first group home. He promptly encountered his usual problems with peer relationships and began running away frequently. His behavior was also becoming bizarre enough that it was felt that he needed psychiatric care. He was placed in the children's division of the local state hospital. After four months, they felt he was improved enough to be placed again, and he was sent to a boys' ranch-type facility.

Whatever improvement that had taken place in the psychiatric setting did not generalize to the ranch, as his behavior was similar to his previous behavior. He was rejected by his peers because of his verbal and physical assaults and his immaturity. He also began running away. After a few runaways, the ranch decided they did not want him back. Since they were running out of placements and seemed to be making no headway, the social services agency brought court proceedings against Tony, and he was adjudicated as a status offender. He was placed in an open camp setting where he stabilized enough for six months that he was placed in another group home. As usual he began running away. During these runaways, however, his behavior took on a new twist, as he began selling his sexual favors to older homosexual males. A few months later, reportedly in a homosexual panic, Tony went to the emergency room of a local hospital and asked for psychiatric care. He stated that he felt he was going to kill himself because he was depressed because his parents and twelve siblings had been murdered, although he retracted the latter when questioned more closely.

Tony was transferred to a state hospital, where he assaulted staff and tried to run away from the adolescent treatment center the day he arrived. He fought continuously and had to be restrained for the rest of the night. The next day

he began complaining of strange symptoms but was fairly cooperative for about a week, when he again assaulted staff and threatened to kill himself. A few weeks later he ran away but was apprehended fairly rapidly and returned. Again he had to be restrained several times for being out of control and violent. Two weeks later he attacked a staff member on the night shift and began beating her. He would have been successful in killing her had he not been interrupted by staff from another unit who were alerted by another patient. The nurse was unconscious when the other staff entered. Tony dropped her and managed to escape. He was picked up the next day in another state. He was charged with assault, adjudicated a delinquent, and was referred to the Closed Adolescent Treatment Center.

As can be seen from this representative case history, the ATE in this book is multisymptomatic. Tony, during his childhood, showed hyperactivity, schizoid tendencies, sexually deviant behavior, depression and suicidal threats, chronic runaway, and violence toward others. By early adolescence, his disturbance was so severe that he was essentially untreatable in any but an institutional setting, and even institutional settings were unsuccessful in preventing his continuing deterioration.

Tony's treatment at the Closed Adolescent Treatment Center was fairly successful. This is not the usual epilogue to youths with this type of case history. More commonly, Tony would have continued his acting out in the juvenile correctional setting, running away, assaulting staff, attempting suicide, etc., and eventually would act out to the degree that he would be sentenced to an adult correctional facility. There, his behavior would earn increasingly regressive moves until he ended up in maximum security, possibly in protective custody. By this time, he would be not only an intensely miserable human being, but also a burden on society for the rest of his life.

The thesis of this book is that youths like Tony can be treated in institutional settings, given the right circumstances and commitment. Because of the excessive social and economic costs of allowing these youths to be untreated, the concept is a vital one.

The remainder of this chapter will deal with the development of this degree of disturbance. The question of why the numbers of this type of youth are increasing will not be answered, as it is obviously a function of extremely complex variables in our society today. There is no question, however, that the problem of how to treat the violent, resistive youth is one of the most critical issues to adolescent workers in our nation.

Early Childhood

Although there are a few exceptions, the majority of ATEs show symptoms of disturbance in early childhood. These are not the situational-emotional

reactions of adolescents to some situational trauma, as described by Marguerite Warren.[1] If there were someone around to tell the story, it is obvious that even prior to entry into the school system there were significant problems. Often there is no clear history, however, because the family situation usually is so chaotic that the disturbance of a small child does not stand out.

Typically, the early concerns revolve around behaviors that indicate the child is attempting to push people away or to reject control by others, usually in a violent manner. The acting out behaviors vary, but often include one or more of the following: physically attacking others, firesetting, frequent temper tantrums, cruelty to animals, vandalism, and running away.

Many, but not all, fit the description of the criminal child in Yochelson and Samenow's analysis of the criminal child.[2] The behaviors are different in quality and quantity from the normal independence-striving of a preschool child. The ATE child is punished often, in most cases with no significant change in behavior. This makes the role of punishment very difficult to interpret. As the punishment is often extreme and violent, it is easy to assume that it is a causative factor in the behavior problems. However, it can be assumed also that it is the intractable behavior that provides the stress on the parents, resulting in their loss of control. Yochelson and Samenow's review of the literature clearly indicates the lack of substantive answers to the question of what causes this type of behavior. Whatever the cause, from early childhood ATEs choose to behave in highly aggressive ways.

The following excerpts from the early childhood portion of the case history of "Tricia" are illustrative of the chaotic and destructive situations that one often finds in the background of the ATE.

Tricia *Tricia's mother is a prostitute, and her father is unknown. According to her maternal grandmother, Tricia's first year of life was extremely turbulent. She was often abused by her mother, who was reportedly schizophrenic and addicted to both drugs and alcohol. The grandmother described one incident when Tricia was crying and her mother tried to strangle her. The neighbors would frequently call the police because they heard Tricia and her younger sister, Dolly, crying. The grandmother would usually respond and find the children unfed, dirty, and their diapers unchanged. When Tricia was about one year old, her mother left town and left her with the grandmother. This was not unusual, because Tricia has a total of six siblings, all of whom are in foster care or some other setting.*

The grandmother also had the responsibility for Tricia's younger sister and her older sister. According to the grandmother, Tricia was the most disturbed of the three girls, and she felt it was because Tricia was the most severely abused of the three. She had severe temper tantrums if she did not get her needs met immediately. As the grandmother stated, "Tricia had to be first and most important."

It is really not certain what kind of care Tricia was given by her grandmother, but it is sure that she tried very hard to get other families to take Tricia and her younger sister, Dolly. Finally, when Tricia was six and Dolly five, their nursery school teacher and her husband (a very young couple) decided to adopt them because they felt the girls needed help. From the beginning both girls adjusted to the new family poorly, although Tricia was by far the worse, mainly because of her uncontrollable temper tantrums. The Browns sought professional help to no avail, and they finally put Tricia in the children's division of the local state hospital. She was there for six months, when the adoptive parents withdrew her against medical advice because they felt she was getting worse. After withdrawing her from therapy, apparently extremely severe methods were used for discipline. The neighbors reported that Tricia was locked in the basement for months and never allowed out. The Browns were also described as very rigid and controlled, and the children were required to sit still with their hands folded when visitors were in the house, and they were not allowed to play with the neighborhood children.

When Tricia was eleven, the Browns contacted the Welfare Department and asked to relinquish her for adoption. The authorities tried to work with them, but their rejection of Tricia was total; they told Tricia they wished they had never seen her. Three years later, they did the same with Dolly.

Predictably, by the time she was fifteen, Tricia had been in a total of ten different placements after the Browns rejected her. She was also acting out quite seriously and was considered highly assaultive and uncontrollable.

Again, this case history is fairly representational, as actual physical abuse and deprivation are not uncommon. Unlike Yochelson & Samenow's population, however, it is unusual to find both parents to be responsible people. In fact, it is quite common for at least one of the parents to have behavior very similar to the child's. An alcohol- or drug-abusing parent seems most likely to produce an ATE, and parents with various mental and character disorders come a close second. Occasionally one can look back through the generations and see, for example, grandparents and parents having identical behavior problems as the child. Whether this is due to genetic or environmental factors, or a combination of both, is not known. However, it is notable that in the population treated by the Closed Adolescent Treatment Center there have been several adopted youths whose behavior was similar to that of a natural parent who had had no contact with the child.

The Early School Years

Public attention is usually first focused on the child when he or she enters school. Prior to that time they are too small to do much damage and are not impinging on so many people. Neighbors, for example, may be able to deal

with assaultiveness with a preschool child by teaching their children to avoid the child. This does not work in the school setting, as the classmates are unable to avoid the acting out child, and parents and teachers necessarily move into protector roles for their children.

In addition to the behavior problems–hitting people, temper tantrums, chronic lying, low attention span, and impulsivity–it is not unusual for an ATE to be a fairly unattractive child. This may be contributed to by parental neglect or abuse, but, for whatever reason, it is another strike against the child. Much research has been done on the effects of personal attractiveness on others, and it is clear that both teachers and peers are more likely to reject an unattractive child.

The question arises as to what percentage of the ATEs is minimally brain damaged, as their symptoms are difficult to separate from the symptoms of minimal brain damage. The answer is that probably very few have identifiable organic problems. This, of course, may reflect difficulty in diagnosis rather than a normally functioning central nervous system. Nevertheless, it is crucial that these children be specially tested for learning disabilities, as their presence immeasurably compounds the problems.

Along with the obvious acting out, and the possible perceptual problems, the young ATE has major problems in relating to both peers and adults. In regard to peers, it is not infrequent that an adolescent ATE has never had a genuine friend. If they have acquaintances, they are what will later be referred to as "sliding partners"–or peers who find themselves in the same circumstances and get some reinforcement in having company in their misery. The shared activities are always negative ones, and the ATE may be a leader or a follower but is seldom just "one of the boys"–an average gang member. His behavior is far too erratic and untrustworthy for him to be included in such a well-structured group.

The teachers are confronted with an enormously problematic child, who often takes more time and attention to just control than the rest of the class. Before the days of strict controls over the schools' disciplinary systems, the young ATEs probably encountered much corporal punishment. In lieu of that, some teachers attempt to effect control by such methods as verbally confronting them in front of their peers. Unfortunately, this usually results in an unexpected effect. Since the young child probably has already experienced derision and hostility from his peers, he eventually becomes accustomed to this and gets some reinforcement out of negative attention–if one cannot do things right, there is some satisfaction in doing a thorough job of doing things wrong.

The next major tactic in attempting to deal with a young ATE in a classroom of normal children is to exclude them, first from the classroom, secondly from the school. Often, they will first be sent regularly to the principal's office, which is unfortunately a reinforcement for both child and teacher. The child

is reinforced by the opportunity to briefly escape from an anxiety-producing situation–the classroom. Even though the discipline received from the principal's office is also anxiety producing, there is a gap in time before consequences are received, which makes the expected behavior very difficult to learn. Also, there is not the added factor of the peers witnessing the situation.

When visits to the "office" do not work, the next step is usually to assign the youth to a classroom designed for youths with similar behavior problems. With many youths, the individualized attention received in such a setting is helpful; with the ATE there is a stronger likelihood that the behavior will get worse. For one thing, the child has many new behaviors to model from peers; secondly, resistance to adult control often increases as they perceive that they can evade consequences for their behavior because they are in a class for "crazies."

The final exclusion is from the school itself, and most ATEs begin to experience suspension from school at a much earlier age than other acting out children. Again, this proves to be very reinforcing for both the child and the school personnel. The child is reinforced by being able to escape the unpleasant situation. The teacher and classmates are reinforced, of course, by the child's absence, and that becomes an easy solution when the situation arises.

In brief then, during the early school years, the clearest lessons learned from school by these children are: (1) they are different from their peers; and (2) by continuing to act out, they can escape from bad situations.

The Placement Years–Pre and Early Adolescence

During the early school years, various social agencies usually begin to get involved in an attempt at treating the ATE and find their efforts unsuccessful. The reasons for this unsuccessful intervention will be discussed at length in chapter 2. The ATE's behavior problems, which have been slowly escalating during the first nine or ten years, begin to skyrocket in pre and early adolescence. This is for many reasons–the disruptive hormonal changes occurring, the increased importance of peer pressure, and the increased opportunity to learn negative behaviors and act on them. It is also at this age that law enforcement and court personnel begin to feel more comfortable in filing criminal charges. A seven year old hitting somebody is one thing–at twelve, depending on the circumstances, it can certainly be considered an assault. It is usual that most ATEs have essentially been breaking the law for years in one way or another, but the consequences are delayed until they seem old enough to accept some responsibility for their actions. Also, as stated previously, new opportunities present themselves. Although young children have fairly free access to various toxic vapors, they usually are fairly restricted from narcotics of various sorts. These become plentily available in most urban junior high schools. Although some sexual problems may be seen in early childhood, it is in early