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Angry Children, Frightened Staff

Earl M. Braxton PhD

Angry Children, Frightened Staff: Implications for Training and Staff Development

Earl T. Braxton, PhD

Children don't care how much you know until they know how much you care.

A major problem for the child care field is finding appropriate staff, then preparing and training them to work effectively with troubled children. The pool of applicants includes many well-meaning adults who claim they "like children," and mistakenly equate this with possessing the necessary technical skills to work in the field. Nothing could be further from the truth. Working with disturbed children, especially in residential treatment settings, is a very demanding and challenging undertaking. Commitment to and caring about children is not enough. In a culture that generally under-values its children, those who wish to help tend to underestimate what it takes to work with wounded children and adolescents.

Unfortunately, funding policies and supervisors' attitudes perpetuate the practice of hiring, and then requiring, the most from the least prepared workers. The pressure on social agencies to maintain programs with limited resources is a key contributing factor to poor service quality and staff burn-out. Agencies often settle for using inadequately trained staff to work with highly disturbed, volatile and vulnerable children. Particularly in

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Earl T. Braxton, PhD, may be written at 211 N. Whitfield Street, Suite 490, Pittsburgh, PA 15206.

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residential settings, coverage may take precedence over training. Managers may make compromises about staff skill requirements because they feel that a warm body on the scene can at least provide maintenance care, which keeps symptoms under control. In addition, there are few accountability standards for personal qualities of staff such as compassion, sensitivity to children, mature judgment or the ability to manage volatile situations, while controlling one's own anger and anxiety.

The typical, inexperienced young adult entering residential care work with disturbed children has an undergraduate degree at best. He or she is between 20 and 30 years old, and is often in the phase of adult development that involves searching for a personal identity. Since undergraduate and even graduate level educational institutions do little to encourage serious emotional growth, young adult staff with little or no experience working with troubled children are likely to become casualties themselves. They must be given emotional and technical skill preparation for their role as care giver. The responsibility for helping caregivers to develop emotional maturity and childcare skills falls on the supervisors in private and public agencies. However, the development of staff is often secondary to the management of programs and if there are fiscal short-falls, staff training is one of the first items to be eliminated. It is usually a crisis that calls attention to the problem of inadequately prepared staff. For example, a typical crisis situation in residential care is children losing control and hurting people or damaging property. They may run away, steal, become physically ill or exhibit serious psychological or psychiatric disturbances. These types of crises are emotionally stressful, particularly to inexperienced staff. Other signs of a crisis include high staff turnover, low staff morale, and staff who provide little or no therapeutic work with the children.

Inadequately prepared staff may include people with good academic credentials but who themselves lack social or emotional maturity. This type of staff may be more adept at hiding their shortcomings through the use of clinical language and jargon. They often find ways to avoid dealing directly with "acting-out" behavior, and instead intellectually distance themselves by using seemingly sophisticated clinical diagnoses, professional jargon and theories to analyze the child's weaknesses and problem areas. Too often when children present their feelings to these professionals by the only means they know (i.e., angry outbursts, impulsive behaviors, dissociative episodes, or sullen withdrawal, and depression), the professional reaction is predictable. The children are often labeled, medicated, dismissed (abandoned), punished, restricted, shamed, humiliated and/or infantilized. All of this is done in the name of clinical proficiency. Because

professionals have control, they can pin all of the pathology on the child, without looking at their own behavior.

We know that troubled children test the inner fiber and character of those who come to work with them. We also know that the child has come to us because he or she was disturbed and needed help to heal the wounds that were caused by the disturbance. These children need to learn alternative ways to manage their internal chaos and anxiety. Staff members who work with wounded children are not paid in a manner commensurate with the demands of their work, but their mission is to provide a therapeutic environment for the children. The staff members are generally expected to work at a "therapeutic level," which includes meeting the child both individually, and in some form of milieu or group therapy. That means that when the child is in crisis, staff members are expected to find alternative ways to help the children to manage their anger, anxiety and pain. We have the right to expect that the staff will rise above the child's limitations. In order to do this the staff person must have inner resources to call on, not just information from books or other people. Staff must have created and built those inner resources before being expected to manage, teach, discipline, love and act as role models for the children.

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

SELECTING AND HIRING NEW STAFF

When staff members are being hired to deal with children or adolescents, they need to be screened regarding their own childhood or adolescence. There is a high correlation between doing effective work with adolescents and "working through" the problems of one's own adolescence. For example, adolescence is a period of inner (and often outer) turmoil. Normal adolescence brings upheavals such as conflicts with parents, various forms of rebellion, struggles with authority, confusion, sexual urges, and experimentation, to name just a few. No one gets through adolescence untouched, although some may deny the turmoil of it. Moreover adolescence replays the development conflicts of our earlier years, so understanding these childhood conflicts is equally essential. In fact, most people were deeply affected, or even traumatized, by their adolescent conflicts and experiences, and continue to struggle with the residual pain in adulthood. In order to discover the ways in which a person has dealt with personal wounds and conflicts, it is critical that we explore with all

potential staff what adolescence was like for them. People who have not come to terms with their own childhood or adolescence will not be open about the conflicts they experienced (during those periods) and they will inevitably lock out the wounded children and adolescents they encounter. They can do even more damage to the disturbed youth if they view the individual through their own unresolved issues, and abuse the authority of their staff position to mistreat the child/adolescent and, in turn, blame the victim.

It is particularly critical to determine how the potential new staff person will handle anger. That may be the most crucial question to explore with any staff person in this line of work. Anger is a healthy emotion and it serves functionally when people are able to manage it, and have a healthy outlet to express it, and do not become frightened by its intensity. Anger has a counter-part and a counter-balance which is the potential for intimacy or closeness. Disturbed children provoke anger because they lack normal outlets for expressing it, and anger is too often their primary feeling. They also defend against closeness because it brings with it feelings of vulnerability. These children will also develop a perception that it is extremely dangerous to be vulnerable in their world. This question should not go unexplored unless we are of the opinion that all anger in the treatment setting comes from the clients, and all staff are above it. When staff cannot face their own anger, they are more prone to mismanage it with adolescents in their care.

Several other important attributes must also be assessed before hiring staff members. The following questions will provide valuable information to the manager facing specific hiring decisions:

1. How willing is the person to look at his or her own personal limitations, weaknesses, and liabilities, as well as strengths, resources and assets?

2. Can the person 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?

   Sample questions:

- How was anger expressed in your family of origin, and how do *you* express it?
- How do you behave when you are sad?
- How do you show others that you care about them?

3. What problems does this person have with authority?
- Describe your relationship with your parents during your adolescence.
- When you had a disagreement with your parents, how did you exhibit those feelings?

4. What is their capacity for intimacy?
- Which parent were you closest to growing up?

5. How well have they managed differentiation from their family of origin? *[This factor is a good indicator of how well the potential staff person can stay out of the child's or adolescent's space without seeming to abandon them.]*
- Who do you depend upon when there is a crisis or problem in your life? Give an example.
- In what way is the relationship with your parents similar or different now as opposed to when you were growing up?
- Describe an important decision you have made in your life and tell how you reached your decision.

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 the staff because their own feelings are triggered by the child. When they begin working without the ability to identify what their own feelings are, they cannot readily distinguish between their own issues and those of the children they encounter.

Staff Problems–Internal and External

Let us now look at some of the issues and dynamics of troubled children which are the most difficult for staff.

TRUST VERSUS CONTROL: THE PITFALLS IN THE AGENCY SETTING

Troubled children see the adult world as both a potentially safe, and a potentially dangerous place, depending on how the adults manage the environment. When the adults around them demonstrate that they cannot manage behavior, children begin to feel that their environment is out of control and therefore not safe. When the environment is no longer safe,

children behave in dysfunctional ways aimed at survival. If they cannot trust the staff to take care of them, they begin to take action to care for themselves by whatever means available. For some children and adolescents, this translates into flight: that is, they run away if they can, or they withdraw. Others, who see the environment as hostile, take a stance of fighting anyone and everyone to survive. To protect the vulnerable parts inside themselves, they become aggressive and attack with little provocation. There are those who try to out-maneuver staff; their tactic becomes "I'll tell you what I think you want to hear so I can get what I want from you, and stay in control." These children/adolescents are constantly jockeying for a way to stay one step ahead of staff, and are quite good at manipulating the situation. They are often highly skilled at "splitting" staff, which takes the form of getting others to be in conflict on their behalf. The child will often lie, play one adult against another, or take advantage of staff mistakes or misjudgments to increase their power. Losing control is their greatest fear. When children feel they can not rely on the staff to take care of or protect them, they behave as if they are in an unsafe environment. They become more occupied with survival than with growth.

THE CHILD'S QUEST FOR POWER

Normal children and adolescents feel powerless because of their dependency on adults. Under healthy conditions (which presume a relative degree of healthiness in both the child and the adult), children are given increased amounts of responsibility as they get older, and are asked to demonstrate their maturity in handling responsibility. It is a mutual exchange and a gradual process which continues until the child reaches maturity, or moves away from the parents and exercises his or her own internalized controls.

Troubled children and adolescents, particularly in treatment settings, tend to have more intense feelings of powerlessness due to their unmet dependency needs and the high degree of structure required by the therapeutic environment surrounding them.

They have often been disappointed, abandoned or violated by the adults they depended upon and, therefore, are already angry and slow to trust any other adults. At the same time, their need to feel secure and safe is heightened by the continuing threats of their insecure inner world. They manage this dilemma by testing and pushing adults. They seek to test the limits so they can determine for themselves whether they can trust or depend on these new adults in their lives. However, they start from the premise that the

adult is untrustworthy, like all the others in their past, and they set out to prove it. It is up to these "substitute" parents to stand up to the test and go the extra mile. This is not easy to do with a child who keeps punishing you for being there while begging you silently not to leave. It is particularly difficult because the adult cannot use the child's overt behavior as the guide post for doing "the appropriate thing"–the adult must have their own inner model of acceptable behavior. Going the extra mile may require either being emotionally available despite intrusive behavior; or it may mean setting a limit for a child who makes you feel like you could not possibly care about them if you don't give in to their wishes. If you cannot meet their demands, or if you leave prematurely, no matter how justified you may be, they will take the position: "I knew you would do this–you see, you really can't trust adults to be there for you." When one adult fails them, all adults come up for scrutiny all over again. Faced with another disappointment the child may respond with uncontrollable rage, withdrawal, suicidal depression–or some extreme behavior that is aimed at hurting self or others.

ANGER AND ARMORING

Anger is the galvanizing emotion of the wounded child whether it is turned outward in aggression and hostile assaults on the environment, or turned inward in deadly, immobilizing withdrawal, depression, or dissociative episodes which are escape routes from overwhelming pain. It is, therefore, critical that any staff person who comes to work with these children must be prepared to work with anger and/or rage (which is a more extreme expression of anger). Anger is the emotion of distancing and separation. The impulse arises in the solar plexus and pushes for release. In more extreme cases, it can result in explosive violence such as physical assault or attack with a deadly weapon. Anger pushes and drives people away. When coming from the wounded child, it is fueled by past hurts and, therefore, is aimed at punishing or hurting a peer or adult in the present. Anger is expressed by striking out, hitting, kicking, biting, scratching, gouging, butting, spitting, or inflammatory and primitive language. Beneath all forms of anger lie the catalyzing emotions of fear, pain and vulnerability. Since the angry child is really a frightened, vulnerable or hurting child, the anger is aimed at keeping people away from the real causations. Expressing or acknowledging the underlying pain and fear often feels dangerous–like giving up one's armor and defenses.

Reich (1972) describes *armoring* as follows:

> Armoring is the result of repeated restrictions of the natural functioning of the body. That natural functioning involves an opening up

> to the natural pleasures of touch, contact, and holding with which babies are born, and which many children manage to maintain. The restrictions children experience can range from the normal neurotic constraints on freedom which stem from learned denial of pleasurable sensations (e.g., "Don't touch your genitals," "That's bad," "Shame on you"), to more pathological restrictions such as parental physical and sexual abuse, rigid, controlling and/or rejecting parents; or sadistic punishment and discipline. These restrictions take the form of muscular contractions in the body which cut off the pleasurable flow of sensations and impulses. Temporary contractions occur whenever a person is threatened or frightened by external stimuli, but continuous exposure to such conditions produces chronic contractions which become a reaction to permanent inner rather than outer dangers. Each restriction of the natural functioning becomes a part of character through contractions which unbalance a person and are a response to anxiety, fear of punishment and rejection. As soon as the natural movement expressing surrender is obstructed by an armor block (contractions), the impulse to surrender is transformed into destructive rage. (p. 374)

Rage is a forceful push of energy occurring when the pain from a muscle block leads to tension, then anger. Blocks also cause children to feel inadequate or like failures, and they turn the affirming "yes" into a resistive "no," or "I won't." Depression results when the energy is withdrawn instead of pushed out. The blocked muscles (armor) also lead to distortions about love. What passes for love is often based on anxiety and hate in the armored person, since the natural flow of emotions is cut off. They are replaced by tension, pain, and a constricting inner experience. Love is then experienced as controlling, holding on, and self-gratifying, rather than expansion, release, and freedom.

Thus, our wounded children have great difficulty opening up to love. That 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 or trust again.

ANGRY CHILDREN, FRIGHTENED STAFF

Inadequately prepared staff will often have their own version of armoring. If they do not know how to differentiate between their fear and anger and that of the child, they are likely to take the child's assault personally.

Once the attack is personalized, the therapeutic boundary–the 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. When the staff behaves as if the behavior of the child constitutes all of reality, then counter-transference occurs.

In counter-transference reactions regarding anger, the staff frequently acts as if they have no power and no objective authority from which to deal with the child. Frightened staff are the mirrors of the hidden fear in their angry clients. Many programs are not structured to address this problem. It is so much easier to neglect staff and allow them to distort issues when there is no holding environment that will help them to work out their own pain. In the absence of such structures, many of our front-line treatment people, especially in residential programs, become covertly or overtly abusive. Staff abusiveness, if ignored in the short run, 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'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. When staff are frightened and have no place to get help and support, they lose control of themselves first, and the children/adolescents they work with next.

Counter-transference–Transference is when the child treats the staff as if they are the authority figures from their past. Counter-transference is when the staff behave as if they are those past authority figures.

Holding Environment structures–Structures that meet the criteria of safety and security to the extent that individuals will risk revealing their inner experiences and covert agendas.

THE PROBLEM OF FEAR

Right next to the child's anger is the adult staff's fear of the angry child. Frightened staff create an atmosphere that feeds the sense of things being out of control starting with that very same staff. The following are some of the effects of fear on adults who work with troubled children:

a. 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 recog-

nize the staff's limitations and exploit them. They are, however, in a double bind. That is, they 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.

b. Fear robs 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 step back 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 it becomes even more difficult to help the child make different choices.

c. Fear causes staff to engage in survival and control tactics rather than therapeutic interventions.

Frightened 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 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 in which everyone loses.

d. Fear causes a split in feeling and thinking.

Frightened staff either become intellectual and lose contact with the child; or they become emotional, and cannot think about the meaning of what is happening. 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.

e. Frightened staff are often irrational, erratic, and uncentered.

Even if frightened staff cover their fear, it 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 counts. 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.

What is needed are structures that enable staff to retain or regain their objectivity and their separateness from the child. Maintaining a therapeu-

tic 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 allows the therapeutic process to unfold over time with safeguards for both staff and children. Offering therapy means creating conditions for change.

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.

HOLDING ENVIRONMENTS–FOR STAFF AND CLIENTS

The adequate holding environment as described in psychoanalytic literature is a metaphor for the security of the infant being held by the mother. The holding environment must meet the criterion of safety, without which the disturbed or anxiety-filled person will not risk rectifying his or her condition (Sandler, 1960; Winnicott, 1965). Safety and security must exist in order for wounded children to risk opening up their wounds to self or others. The agency or organization is responsible for the creation of the requisite conditions. Since 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.

The adequate holding environment for staff in child/adolescent treatment settings has the following attributes:

a. Staff needs the opportunity to come together and express their experiences of frustration and anger with (1) the children whom they are working with; (2) the administration to whom they are responsible. Staff need to have the space for an emotional catharsis about the way in which their young clients impact them and their feelings about the authority figures with whom they must comply. They need to be free to say and express whatever it is that is bothering them no matter how critical, ugly, violent or destructive it may sound. Only after there is genuine freedom to express such feelings can the staff move to the next phase of a holding environment.

b. Once the feelings are out, staff need to be able to find the meaning of their experience. What are their emotions telling them about the problems they are facing? What understanding can they develop by considering what messages are contained in their behavior and that of the children for whom they provide services? The opportunities have a better chance of succeeding if all or at least some of the sessions have an external consultant assigned to them. It is very difficult for the supervisor of a treatment setting to enable the staff to look at the systemic and authority issues that are impacting them when he or she may be a part of the staff's problem(s).

An adequate holding environment for children has very similar characteristics:

> There need to be regular group meetings that encourage them to talk about the problems they are having both individually and as a group in their therapeutic environment both with staff and other clients. They also need to connect current experiences with past events, thereby gaining insight into their own behavior. This then gives them the tools to take more responsibility for their behavior.

Abandonment and intrusiveness are the antithesis of a good holding environment (Modell, 1976). Either of these behavior patterns will produce fragmented and disintegrated systems. Thus, a goal for agency management in providing a good holding environment for staff is to offer them support and 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. 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, then the children tend to lose their boundaries and express themselves in angry episodes, temper tantrums or limit-testing. Unless adult care-givers 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.

Holding Environment Problems Identified

The main conditions which interfere with the healthy expression of inner experiences in family life, and likewise, in a therapeutic holding environment, are:

a. the depressive condition and
b. the paranoid condition. (Klein, 1959)

The depressive condition is the fear of total indifference from others. It is set off 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. The depressive condition represents the fear that if I put out what I really feel inside, no one will be there for me. I will be abandoned and/or it will become only my problem and I won't have the means to help myself.

The paranoid condition is the fear of retaliation. "What will someone do to me if I say what I really feel?" It is set off when people attack or criticize staff or children for having the feelings they have, or daring to express them. When the expression of a feeling is treated like a violation or attack on others, then self-ventilation is avoided as a dangerous activity, e.g., "I'll lose my job"; "The staff will hate me."

These issues are related to both the client peer group and the staff peer group. Both of these conditions arise out of a perceived scarcity of caretaking resources* in the larger group system. When these conditions exist, children and/or staff begin competing for what is perceived as a scarce commodity.

It is difficult to correct problems arising from this dilemma and to maintain a holding environment, unless staff are willing to be confronted about their roles. Parents, or staff (who cannot acknowledge their own problems), tend to develop systems (families, groups, etc.) that are unable to be cohesive or responsive. The adequate holding environment requires staff to be available to the child when needed, but not to be intrusive or abandoning. The symptoms we see in systems where children become unresponsive, closed down, or impotently accommodating, are as much a result of flaws in the holding environment as they are a result of an individual's pathology or developmental issues. Training the staff to manage their own anxieties, to work with their fears, and to develop the requisite intervention skills to genuinely help troubled children requires specific training. Agencies often act "penny wise and pound foolish" by cutting the corners on staff training and development, and paying the price in child and staff turnover. An agency is only as strong as the staff who run it–from the administrative level on down.

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* Caretaking resources, in this sense, are: Safety, love, acceptance, shelter, kindness, warmth, altruistic caring, tolerance for human faults and failings, and ability to "be with" others in pain.

STRENGTHENING THE THERAPEUTIC SYSTEM

There are several staff and agency development strategies that strengthen the therapeutic quality or responsiveness of any treatment system.

1. Use of clinical consultation at the administrative level can help both management and the larger organization to see the 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. Creation of a support system must include adequate clinical supervision for staff members who provide direct service to the client population. The staff also need the opportunity to share their individual experiences about working with the children and with 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 sibling rivalry and competitive impulses with each other. The wish to look like one is in control by minimizing conflicts and objectivizing issues interferes with the adequate "holding environment." Therefore, each staff level, from administration to line-staff, 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. Development of a training plan should emphasize the strengthening of the psychological/emotional capacity of the staff, and then focus on building its skill level and knowledge. The latter is meaningless without the former. No matter how much they know, staff will remain highly vulnerable to the emotional pulls of troubled children (countertransference) when there is insufficient attention given to maintaining staff's emotional and skill development. Moreover, the training must be an ongoing interconnected process, not a series of hit or miss "events." There must be a "training plan."
4. A training program must be ongoing, comprehensive and competency-based, rather than information-based. Competency takes more time to develop, but deepens the staff's abilities and commitment to the work. It focuses on the "how" of behavior, and the skills necessary to get results. (For example: "What does it look like and feel like to effectively calm down a distraught child?").
5. There needs to be a requirement that every staff member be well grounded in child and adolescent development–taught by skilled

practitioners. There is no substitute for this knowledge. Its absence is the source of some of the most destructive staff behavior. A solid grounding in the research findings concerning therapeutic treatment of disturbed children is also necessary for effective functioning on the part of staff.

6. Management training needs to be provided for supervisors and middle management personnel. Supervisors need to have their clinical skills upgraded and new intervention techniques should be taught to improve the quality of the overall treatment process.

Social agencies often ignore good management and create their own turmoil by not managing the work system well, and thereby causing staff disenchantment and casualties. A supervisor who is technically or emotionally unprepared for the task affects many other people, and can interfere with the creation, development and maintenance of an adequate staff holding environment.

SUMMARY

In summary, it is at the service delivery level where the most direct and frequent contact occurs between children and the staff, who in turn must be able to manage their fears and anxieties and make the child's needs their first priority. First of all, staff must be adept at establishing and maintaining relationships with children or adolescents. That is the basis for providing the environmental conditions that allow the child to feel connected and held. Secondly, staff must be able to provide consistency, limits, and loving confrontation to the child, no matter how ugly the child's behavior may be. Thirdly, staff must know where their own boundaries or limits are, and make the child aware of the pain he or she creates for others (including him or herself) without being punitive. In order to do this staff will need training and a holding environment that raises their psycho/emotional capabilities, their skills and competencies, and their ability to translate the child's negativistic or "acting-out" behavior into an awareness of the real issues.

Agencies also need a strong clinical supervisory process, a supportive administrative system, and an adequate holding environment at the staff level in order to meet the needs of the hurt/angry child. Staff development and agency consultation and training can enable systems to develop these structures and processes. Strategies currently exist to help administrative, supervisory, and treatment team personnel to build the needed holding environment for themselves and their clients. The place to begin is by

doing an assessment of the staff to find out what they consider as the strengths and weaknesses of their program. They can also be invited to suggest ways the program can be improved. The client system can be interviewed for their own personal perspective. Once the data is collected it may be used to elicit the cooperation of everyone for developing and implementing a plan.

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