5

Institutional Treatment Programs for the Violent Juvenile

Vicki L. Agee

INTRODUCTION

Institutional treatment for the violent juvenile is known for its rarity. The majority of violent juveniles are passed from one program to another until they end up in an adult correctional setting, where they usually receive no treatment at all. Both the mental health systems and the youth correctional systems find the violent juvenile aversive, although there have been a few programs that have attempted to deal with this very difficult population.

The rationalization presented by the majority of mental health professionals is that most violent juveniles have "character disorders" and thus are not amenable to treatment. Yochelson and Samenow (1977) state that institutions have failed in their attempts to treat characterological problems because they have applied the same methods to treat them that they have used with noncharacterological patients. They cite Miller and Kenney (1966), who stated, "No one has ever demonstrated that problems of delinquency can be successfully treated on a large scale in a psychiatric facility. We cannot treat misbehavior" (p.47).

Yochelson and Samenow (1977) also cite Silber (1974), who agrees that the traditional psychiatric approaches do not fit for the characterological patient: "Mental hospitals have the wrong 'set' for treating felons: they perceive the patient as helpless and disturbed. Most criminals are not out of contact with reality, but rather are deviant in social values and behavior" (p. 241).

Unfortunately, the diagnosis of "character disorder" in adolescence often has been broadened to include any behavior disorder, and behavior disorders are by far the most predominant symptomatology of adolescence. Schizophrenia is a disease that appears most often in late adolescence and early adulthood, but is not a common diagnosis in the adolescent years. Most treatment programs in mental hospitals are designed, therefore, for the rare schizophrenic adolescent, plus those equally rare adolescents who have no outstanding behavior disorders.

Why is it that mental hospitals seem to have such difficulty in dealing with behavior disorders? One would assume that with their staffing patterns (which are rich compared to correctional settings) and their access to psychotropic medications, they would have little difficulty in handling behavior disorders. What seems to occur confirms what the authors cited earlier conclude: The mental health system does not understand much about dealing

with the violent juvenile, and to date most have been unable to redesign their treatment approaches to deal with this population.

The youth correctional system generally finds itself heir to youths who are rejected from the mental health systems because they are "non-amenable to treatment." Sometimes, of course, they receive youths who have not had mental health evaluations directly from the courts, and sometimes they receive them after they are rejected, but the majority of violent adolescents end up in our nation's youth correctional systems. The majority of the youth correctional systems, unfortunately, are even more poorly prepared to deal with them than the mental health systems. Their staffing patterns are traditionally at custodial level only, and staff pay, staff training, and administrative support are totally inadequate for the job they are required to do, that is, to treat the youth whom the mental health system has been unable to treat.

Almost anyone who has worked in an institution that deals with youths with severe behavior disorders knows that there are two ways to leave a treatment program. One is by improving behavior, and the other is to misbehave so badly that the program rejects the youth. This contributes to the "hot potato" syndrome in dealing with violent youths. Each move usually becomes a regressive one in that youths are likely to find themselves in programs that limit their freedom to increasing degrees.

Unfortunately, the majority of violent youths do not see each institutional change as a regressive move, but as a victory for refusing to allow others to control them. As explained in Agee (1979), it doesn't take long for them to feel invulnerable to any attempts at changing their behavior through treatment. And this compounds the already difficult treatment problem.

Tennenbaum (1978) stated that staff perception of "dangerousness" within a juvenile institution was inversely related to a desire to work with a youth. Bewildered and frightened staff are often presented with the dilemma of having to both manage and treat behavior in youths who have a long history of perceiving reinforcement for: (a) acting out violently against others; (b) having a deviant value system; and (c) sabotaging attempts at treatment. There is little wonder that few programs have been designed to work with this type of youth.

REPRESENTATIVE INSTITUTIONAL TREATMENT PROGRAMS

With the exception of the author's program, the Closed Adolescent Treatment Center, most treatment programs for the violent adolescent are fairly new, particularly those that specialize in treatment of the violent juvenile sex offender. The following are some examples of programs in mental health facilities, youth correctional facilities, and joint mental health–youth correctional facilities. The first example is of a mental health facility for violent juveniles.

Thistletown Regional Centre, Syl Apps Campus (475 Iroquois Shore Road, Oakville, Ontario L6J5E8), Clark Deller, Director

The Syl Apps program was in the planning stage for several years before opening in 1981. Planners visited several programs in the United States and Canada and did considerable research and staff training before opening their doors. The program is contained in two

cottages, each with a capacity of 8 to 10 youths. It is unusual in that it is a mental health program specifically designed for violent youth. Usually, more than half the youths in the program at any time are sex offenders (either rapists or child molestors) and the rest are assorted other violent offenders. As is typical of mental health programs, the staffing ratio is quite high. There are 14 direct care staff in each unit of eight youths. The treatment approach is an eclectic one, and still in the developing stage.

In recent years, some youth correctional institutions decided to concentrate their most difficult youths in one cottage in order to protect them from influencing the "average" delinquents. They soon found it necessary to staff this type of cottage more highly than the usual single (or occasionally double) coverage of line staff. This was necessary if for no other reason than to prevent this collection of dangerous youths from assaulting staff and each other and escaping. It was found to be particularly necessary if any semblance of treatment was to take place. Even with increased staffing ratios, the staff-client ratio generally remained well below that of a mental health program, and the facility and all ancillary resources are generally of the austere nature reserved for correctional settings.

In spite of the drawbacks, several programs of this nature have survived and even flourished in correctional settings. As an example, the Lookout Mountain Center in Golden, Colorado (which originally was the boys' training school), has two such units, Oak and Blue Spruce. The former is described here as a program example.

The Oak Unit, Lookout Mountain Treatment Center (Golden, Colorado 80401), Darlene Miller, PhD, Director and John Davis, Treatment Team Coordinator

The Oak Unit has been in existence for 8 years. The staffing ratio of 14 staff to 18 youths is higher than the usual ratio at the institution of 11 staff to 24 youths in a cottage. The Oak Unit receives some of its violent incorrigible clients directly from the courts and some are transferred from other cottages after revealing strong resistance to treatment attempts. The treatment approach is mainly group-therapy oriented. All of the youths meet together in a community group three times a week, although group meetings may be called several times a day if there is a disturbance in the peer culture. In addition to the community group, the youths are involved in skill building groups which meet four times a week. These groups vary in content, but are educational as well as therapeutic. Samples of areas of concentration in skill building groups are: human sexuality; assertiveness training; values clarification; drugs and alcohol; social survival skills; and relationship awareness training.

Because there is a large number of sex offenders in the program, the sex offenders also have a separate group that meets four times a week. The emphasis in sex offender group is to raise awareness of victims and to teach the offenders to recognize thinking patterns in their rape cycles and change them.

In many respects, a combination approach to working with the violent juvenile is ideal. State mental health systems often have the resources in the way of staff, and in some respects in theoretical background, and the correctional systems often have the youths themselves. In addition, although lacking resources, the correctional staff often have the right "set" for working with the violent juvenile. For example, because they have long experience at being on the receiving end of youths that no one else wants to treat, they have experience with a wide variety and degree of disturbance that is often denied to mental health staff in settings with selective admission policies. For another, because they are particularly familiar with character disorders in juveniles, understanding of their cognitive

processes is unlikely to be as naive and easily influenced as that of staff who don't work constantly with skilled manipulators. Finally, because they work in a correctional area, they are more likely to be capable of dealing with violent acting-out behavior because it is a fairly constant companion to their jobs.

The Closed Adolescent Treatment Center (CATC) described in the following paragraphs is an example of a program that began as a combined effort between mental health and youth correctional institutions to provide treatment for the violent juvenile.

The Closed Adolescent Treatment Center (3900 South Carr, Denver, Colorado 80235), Vicki Agee, PhD, Director

The CATC was opened in 1972 on the grounds of a youth correctional institution. It was funded by a Law Enforcement Assistance Act (LEAA) grant and was designed to be a cooperative program between Colorado's Division of Mental Health and Division of Youth Services to treat the youths (both male and female) who were considered the most violent and incorrigible in the state. The staff was hired by the Fort Logan Mental Health Center and they provided supervision. The facility and all ancillary services were provided by the Division of Youth Services. The original facility had a capacity of 18 youths, but after the first year of the program, it was moved to a facility that housed 26 youths. The total number of staff was 26. Staffing around the clock and on weekends, there are an average of three to five staff members on any shift.

The clients at the CATC are all violent offenders committed by the courts. As is similar in most programs for the violent offender, about half the population are sex offenders. Another fourth of the population are murderers, and the remainder are assorted other violent offenders.

The treatment program at the CATC is extremely complex, but centers around the therapeutic community concept. The major therapeutic modality is group therapy, and group meetings are held daily. The peer group is guided by staff in treating each other, and treatment is considered to go on at all times. The groups are homogeneous groupings based on Marguerite Warren's Differential Diagnostic Typology, Interpersonal Maturity Level Theory (1966). Staff are also matched with students for treatment purposes using this typology. Therefore, group, individual, family therapy, and all treatment planning are done by matched staff.

In addition to the daily groups, there is a separate sex offenders group (very similar to that at Oak Unit) and a separate group for murderers. Both of these groups meet once a week, and are in addition to the daily therapy groups. Other programming involves a remedial school program; a life skills program; recreational and occupational therapy; and an intensive community reintegration program.

During the first 3 years of the program, the Law Enforcement Assistance Administration also funded a separate independent research study which essentially did a cost-benefit analysis of the program. The study was quite complex, although the number of subjects was small. The results indicated that the unit was quite cost effective. Since the study was completed, the only research has been on recidivism to adult corrections, with the average recidivism being 33%.

After the LEAA funding ended, the CATC was funded by the State of Colorado. For

purposes of efficiency, it was placed totally within the Division of Youth Services, rather than remaining a joint program. The philosophy of the program remains one of a joint mental health–youth correctional approach.

In many treatment programs, sex offenders are separated from the rest of the violent juvenile offenders and treatment programs are designed specifically for sexual disorders. Knopp (1982), of the Prison Research Education/Action Project, described examples of these homogeneous programs, as well as the programs that combine violent juvenile offender populations in her review of treatment programs for adolescent sex offenders.

Reasoning for separating the population of sex offenders from other violent offenders usually revolves around the need for protection. Sex offenders (particularly child molesters) are usually at the bottom of the peer hierarchy in an institution. This culture mirrors that which is found in adult correctional institutions. Probably this is one of the reasons sex offenders characteristically deny vehemently that they are guilty (even if they were apprehended in the act). Separating the populations then presumably makes the juvenile sex offender feel physically safe from harm from other offenders, and also contributes to lessened emotional stress stemming from peer rejection.

It should be noted that some programs, such as the Closed Adolescent Treatment Center and Oak Cottage at Lookout Mountain School, have a combined approach. That is, although the violent juvenile offender population is a mixed offense group, the sex offenders in each program have separate therapy groups to work on their sexual problems. Both programs, however, have a rich enough staffing ratio to provide the physical protection the sex offender seems to need.

The following program, the Intensive Change Sex Offenders' Program, is located in a unit for violent juvenile offenders, but is even more of a separate program than the CATC and Oak programs.

The Intensive Change Sex Offenders' Program, Maine Youth Center (675 Westbrook Street, South Portland, Maine 04106), David Berenson, Unit Director

The Maine Youth Center is the state's only juvenile institution, and the Intensive Change Sex Offenders' Program (ICSOP) is a part of the Cottage 1 program on grounds, which is primarily for violent offenders. There are 30 adolescents in the Cottage 1 program, and about 20% to 30% are sex offenders. Most of the latter are in the ICSOP program.

The ICSOP uses an eclectic treatment approach based mainly on the work of Yochelson and Samenow (1976, 1977) and William Glasser (1981). In addition, they have a therapeutic community approach called the Intensive Peer Culture. Youths are held responsible for each other's treatment, and this process is taught by and carefully supervised by staff. The Yochelson and Samenow approach is used in the treatment program to analyze inappropriate thinking patterns and to learn deterrents to these patterns. A daily journal of the youths' thought processes is kept and carefully analyzed for criminal personality thinking errors. To assist in their analysis of thought patterns, the Glasser BCP Model (1981) is used as a tool to help in learning.

The ICSOP is a fairly new program in the process of developing, but already is using some unique and promising approaches to working with the sex offender.

CHARACTERISTICS OF TREATMENT PROGRAMS FOR THE VIOLENT JUVENILE OFFENDERS

With only a few exceptions, the programs designed to treat the violent juvenile offender have many aspects in common. Most, for example, have as a major treatment emphasis a therapeutic community, or positive peer culture approach. Second, most have structured treatment programs that provide youths with ongoing behavioral feedback. Third, most use a team management approach with staff and have a high quality (and quantity) of staff. Fourth, most have developed a discipline system that is prompt, and have some sort of specialized approach in working with the sex offender portion of the violent juvenile offender population. Finally, most of the programs feel that a secure setting and adequate time for treatment are critical in their success. Each of these areas will be discussed in more detail in order to describe the philosophical sets that seem to be important in working with this very difficult population.

The Therapeutic Community Concept

Dr. Maxwell Jones (1953) was an early pioneer in the treatment of the sociopathic patient. His therapeutic community approach was one that would be replicated, expanded upon, and eventually become a popular approach with many different patient populations in addition to character disorders. At about the same time, the Highfields Program in New Jersey (Weeks, 1958) was developing the concept of Guided Group Interaction, and this concept also spread rapidly and was expanded upon. The numerous self-help groups in institutional settings and in the community were generally versions of these positive peer culture or therapeutic community approaches.

Examples of such programs are: Synanon, Delancy Street, Elan, and Vision Quest. These programs are quite different and designed for different populations (the first two generally for drug abusers, and the last two for adolescents with behavior problems), but all revolve around the concept that peers are responsible for treating each other. Harry Vorrath and Larry Brentro were leaders in utilizing these concepts in youth correctional settings and describe the concepts in their book, *Positive Peer Culture* (1974).

There is much similarity between the "therapeutic community" concept and that of the "positive peer culture" as described earlier (Agee & McWilliams, 1984, pp. 283–284*). They both espouse the following treatment approaches or philosophies:

1. The concept that the patient is responsible for his behavior. This may not seem to be a particularly radical concept, now, but in the heyday of the medical model, the patient was considered "sick" and therefore needed "treatment" applied by doctors. The therapeutic community rests on the understanding that the patient is capable of taking an active role in his own treatment.

2. The concept that the positive peer group is the most effective mode of treatment. A positive peer group is a group whose values and interactions reinforce thinking and behavior which is consistent with that of the core culture (e.g., integrity, hard work, mutual support, division of labor, etc.). A negative peer group, of course, reinforces values which are not only counter to

*Note. From "The Role of Group Therapy and the Therapeutic Community in Treating the Violent Juvenile Offender" (pp. 283–284) by V. Agee and B. McWilliams, 1984. In R. Mathais (Ed.), *Violent Juvenile Offenders.* San Francisco, CA: National Council on Crime and Delinquency. Copyright 1984 by National Council on Crime and Delinquency. Used with permission.

society in general, but which are usually harmful both to members of the group itself, and to others. Typical examples are the "con code" which exists in some psychiatric settings. The therapeutic community is designed to create a positive peer culture which in turn confronts negative behavior in its members and teaches positive behaviors.

3. The individual patient and the positive peer culture are held responsible for the treatment and management of the unit. The degree to which this takes place varies considerably in different treatment settings, but all therapeutic communities reject the medical model concept of a passive patient who is cared for by the nursing staff. The patient is held responsible for managing his own affairs and that of the group. In self-help settings such as the drug treatment program, Synanon, this responsibility was more or less considered to be a lifetime one. After successful treatment, patients would become treaters and continue living in the program permanently. In many mental health programs, the responsibility ended when the short term of hospitalization was over.

4. The responsibility of the staff in a therapeutic community is to help create and maintain the positive peer culture by careful guiding of its functioning. The staff in all therapeutic communities functions as a team and is itself expected to be a role model of a positive peer culture. The team model replaces the traditional hierarchy of the medical model—with the physician or psychiatrist making all of the decisions, the nurse supervising the implementation, and the psychiatric technician carrying out the direct care. Although the management system varies considerably from setting to setting, all therapeutic communities promote considerable input into treatment and programming at all levels of staff.

During the past 20 years, many felt that the therapeutic community–positive peer culture approach was the final answer for treating disturbed youth. The most obvious benefit was the use of peer pressure to control and, it was hoped, provide treatment to the youths in the program. The typical power struggle between adolescents and adults is increased greatly in a population of disturbed adolescents. In a therapeutic community, however, the control battle is avoided. The group values revolve around the philosophy of "we" rather than staff versus peers, or peers versus each other. Like an ideal extended family, problems are handled within the group, as they affect everybody. The youth who has had longstanding problems with interpersonal relationships learns how to meet the expectations of others and how to establish meaningful friendships. The youth who has successfully resisted becoming a contributing member of society cannot avoid the social framework in the therapeutic community. It pervades his or her existence, and it does this during a life phase when peer influence is paramount in importance. In addition, the therapeutic community confronts and attempts to reverse negative delinquent subculture values in youths before they become as habitual as they are in much of the adult criminal population.

If the therapeutic community approach is so ideal for working with juvenile offenders, why isn't it in general use in institutions? And, in fact, why was it considered a failure in many programs that attempted to use it? There is no simple answer, but there are some general problems that typically arise when attempting to use the approach.

One of the major problems revolved around the conflict between the treatment philosophies of the medical model versus those of the therapeutic community. Those who espouse the medical model see their patients as having primarily intrapersonal disorders, and thus they emphasize the one-to-one relationship between the patient and therapist. The therapeutic community model was originally designed for sociopaths with a major focus on treatment of interpersonal problems. Group therapy was thus the treatment of choice. In addition, the medical model stressed the use of psychotropic medications to control behavior, while the therapeutic community model resists the use of medications because they mask the behaviors that the group must observe in order to change. Also,

the medical model stresses the shortest possible treatment time, so that patients are released as soon as minimal behavioral control is achieved. Therapeutic communities, on the other hand, take time to develop and cannot thrive where there is a rapid turnover in population. Finally, the power or authority in a medical model treatment program always rests in the physician, whatever the actual formal role of that person. Therapeutic communities cannot function effectively unless the power source in the program rests in the group leader, and thus with the group itself. This is to ensure that the group can realistically meet the expectation that it is responsible for the unit; it cannot be responsible for something it cannot control.

These are just a few of the major conflicts between the medical model and the therapeutic community model, but it can be seen that the two do not combine well at all. Unfortunately, what occurred in many psychiatric settings was an attempt to combine the philosophies with negative results. Sacks and Carpenter (1974), in their article on "The Pseudotherapeutic Community," describe what occurred in many settings.

In addition, there were conflicts with the traditional correctional organization when the therapeutic community approach was used in youth correctional facilities. The fairly rigid hierarchy of authority and pervasive distrust of mental health staff made it almost impossible to provide the individual units with the autonomy and support necessary to establish therapeutic communities. One example is the typical division in correctional settings between "group life" and treatment staff. The former handle security, discipline, and daily living experiences. The latter see the inmates on a periodic basis for therapy and then return them to their various living units. This usually results in the therapist being the "good guy" who is seen as a sympathetic listener, and the group life staff being the "bad guys" who enforce rules. Obviously there is no way to model a team or positive culture approach to the peer group with this type of staff structure.

For a time during the 1960s and 1970s, the therapeutic community approach was used with many other populations besides the "sociopaths" for which it was originally designed. The problem with this, of course, was some types of patients do not have the internal resources to be therapeutic with each other. Chronic schizophrenics, for example, may marginally exist in a therapeutic community, but they are certainly not capable of running one. Because of their thinking disorders, they are totally self-involved. Their problems are intrapersonal. Although they may learn rudimentary responses in a therapeutic community, they do not change their thinking patterns, and might even experience undue stress from the unrealistic expectations on their interpersonal skills.

At first glance, the violent juvenile offender, with his or her usual long history of sabotaging attempts at intervention and poor interpersonal relationships, would seem to be about as likely to benefit from a therapeutic community as a schizophrenic. The vital difference is that while the interpersonal skills of the violent juvenile offender are characteristically poor, the majority of them can be taught the behaviors necessary to be therapeutic with each other.

Unfortunately, this requires very special circumstances. Therapeutic communities are extraordinarily difficult to create and maintain, particularly with a population skilled in creating a negative peer culture. Nevertheless, the approach has not only been seen to be feasible, but the treatment of choice in most settings working with the violent juvenile offender.

Structured Treatment Programs

Many of the original therapeutic communities had very little, if any, structure, and in fact, some practitioners felt structure was counter to the philosophy. Harry Vorrath and Larry Brentro (1974), for example, were strongly adverse to using any ancillary treatment tech-

niques with their positive peer culture, particularly the structure of "behavior modification" or point and level systems. What structure did exist in many programs was unidimensional. That is, the structure was limited to daily or weekly time schedules (e.g., Community Group was held at a certain time on a certain day). If there was any written program at all, it usually gave the schedule, the philosophy of the unit, and some rules (there was usually little said about consequences of breaking the rules).

The developers of treatment programs for the population of violent delinquents generally design an intricate, extremely structured written treatment program as a critical adjunct to the therapeutic community. There are several complex reasons for this, but the major one is the need to address the problem that the majority of the youths have character disorders and typically have manipulated or intimidated to avoid numerous previous attempts at treatment. Usually they are particularly expert at avoiding unidimensional type programs. For example, if they were in a program where it was necessary to earn points to progress through a program, they quickly became adept at "point scoring" while continuing their usual negative behaviors when there was no one around to score them down. In programs where there was strictly group therapy approach, they often became adept at appearing very sincere and therapeutic in group, and then becoming their usual intimidating selves outside of group, or around staff that was not involved in group.

To clinicians skilled in working with this population, every facet of the program must have a system that backs it up in such a fashion that it is very difficult for a youth to avoid the pressure of critically examining his or her behavior. For example, a youth may earn enough points from a scoring system to qualify him or her to move up a level in the program. However, the peer group may not approve the promotion because they feel the behavioral changes were not genuine. In this example, the youth quickly realizes that "point scoring with staff" is not enough, and must also impress his or her peer group with behavioral changes. To further expand the concept, the program may require that a youth make a commitment to the group to use some positive behavior alternatives and be confronted at any time outside of group by peers for not following up on these commitments. The ideal therapeutic community is a pervasive concept. The quality of interpersonal relationships is the major focus during all waking hours, not just during formal therapy times. For example, it is considered as important for the youths to learn how to relate while washing dishes as it is while telling their innermost secrets in group therapy. Therefore, the unidimensional schedule of daily activities is of minor importance. The total emphasis in all activities is on relationships—who is relating to whom, about what, and what is the quality of the interaction. This added dimension provides a depth that was missing in some previous attempts at establishing therapeutic communities with this population.

Another problem that often occurred in unsuccessful attempts to treat the population of violent juvenile offenders with a therapeutic community model was the lack of emphasis on victim awareness. The traditional mental health system considers its first responsibility to be to the patient, rather than to the community. Workers within this system usually take a very protective nurturing stance with their clients which is definitely not appropriate with the character disorder type of patient, who is looking for any excuse to deny responsibility for misbehavior. Rather than changing harmful behaviors, the result was more often that the behaviors were reinforced, as they often received much kindly attention and support after acting out. It was Glasser (1965) who first began emphasizing the importance of making the patient feel responsible for his or her own behavior, and apparently many of his insights were achieved from working with a population of delinquent girls. This concept has been expanded upon in most current treatment programs that work with violent juvenile offenders, so that the whole process of becoming acutely aware of the negative effects of their behaviors on their victims is a major part of the treatment process.

Adding further intensity to the treatment programs are such significant additions to the program as family therapy; one-to-one relationships with assigned staff; recreational and occupational therapy programs; life skills and community reentry programs; and the educational program. Unfortunately, it is not possible to discuss all of these program components in a short article. The important point to be made is that most treatment programs for the violent juvenile offenders are all-inclusive in order to provide the support and guidance to nourish a positive peer culture.

Team Management Approaches with Staff

Quality of staff (and to some extent quantity) is also seen to be a critical factor in developing and maintaining a treatment program for violent juvenile offenders. A positive peer culture cannot exist in the absence of a positive staff culture. Even if hiring is of necessity via a typical civil service, the staff culture must be such that high quality people are attracted to the system, and once hired usually make a long-term commitment to the unit.

In addition to selecting people who are personally exceptional, staff selection must also be keyed toward people who function well in a team system. There are some individuals who may be excellent therapists in their own right, but who just cannot relinquish enough autonomy to function as a member of a team and therefore cannot contribute to a therapeutic community with violent juvenile offenders. The concept requires that staff work so closely together as to almost appear to be a gestalt organism. This is because for one thing, they must appear as role models of cooperative interpersonal relationships to the peer group; and for another, the violent juveniles are obviously dangerous, and maximum safety is achieved through cohesion.

In an ideal family, the parents present a united front to their offspring. In the therapeutic community, the same thing must occur. Violent juvenile offenders usually have much experience at being able to split staff (and their own parents) and set them up against each other in an effort to divert attention from their negative behaviors. Ideally, in a team setting, there are very strong values against allowing this to happen, and attempts to do so are promptly confronted.

The team approach is very similar to the highly touted Japanese system of management. For one thing, staff in these programs usually make a long-term commitment to the job. Second, they are generalists. That is, no matter what one's training or experience, everyone has many of the same tasks. For example, the team's special education teachers may conduct the education program for part of the day but also have other tasks, such as supervising daily living experiences; disciplining youth; having one-to-one caseloads; and participating in all treatment planning. Similarly, the team psychiatric nurses may spend a small percentage of their time on medical responsibilities, but the majority of their time is spent in treatment and supervision of the peer culture. Third, all staff have input into the treatment planning and carrying it out. Although in most therapeutic communities there is a hierarchy (with the group leader being at the apex), staff at all levels participate in decision making and planning. As with the Japanese system, the administrative staff of these programs generally see that their function is to provide the resources for the staff to do their job in the highest quality manner possible. This provides the critical support necessary for staff to devote their energies to treatment rather than to resisting authority as they do in many settings.

A final staffing consideration that is considered a strong asset in some programs that treat the violent juvenile offender (such as the CATC) is the matching of staff and students along certain personality dimensions. At the Closed Adolescent Treatment Center, this

matching is done on the basis of Marguerite Warren's (1961, 1983) Interpersonal Maturity Level Theory and is a complex concept. At least on an intuitive level, the matching seems to greatly facilitate staff–student relationships, and thereby aid in the treatment process.

Effective Discipline Systems

Partly due to their violent and intimidating behavior, and partly due to an acquired skill at sabotaging attempts at controlling them, teaching the violent juvenile offender self-discipline is an overwhelming task. However, as William Glasser (1965) has stated in his Reality Therapy theory, the need for self-discipline is one of four basic needs to be met in order to learn responsible behavior. Often the violent juvenile offender has to have almost a complete resocialization in order to achieve this goal.

The concept of giving "natural and logical consequences" as developed by Dreikurs and Grey (1970) has been helpful in designing discipline systems in treatment settings with the violent offender. Of course, it is difficult to provide "natural" consequences for misbehavior in an institutional setting, but it is possible to design a system that provides consequences that are as logical as possible, and certainly prompt and effective. Gadow and McKibbon (1984, p. 315) summarize the design of such a system as follows:

> First, it is necessary in working with the violent juvenile to have a treatment program which clearly spells out the structure of the program, including the rules which are designed to promote socialization and the offenses which are considered serious and not to be tolerated. The consequences for these major and minor offenses are spelled out in detail in the program, in order to provide the consistency that did not occur in the childhood of the offenders. It is vitally important that this structure be very detailed and that the youths know that certain behaviors will inevitably result in certain consequences, and there is no way that they can manipulate or intimidate their way out of the consequences.
>
> In a therapeutic community, such as the CATC, the positive peer culture sets the standards as to what is acceptable and non-acceptable in their peer culture, although this process is guided by staff, and is done within the structure of the overall treatment program. All staff and peers are expected to confront misbehavior, whether it is behavioral or attitudinal, as soon as it occurs. This is such a strong value in the peer culture that the person who does not confront negative behavior is considered equally guilty as the person who is misbehaving. The rationale of course is to teach the value that stopping people from hurting themselves or others is a caring thing to do in our society.

The concept of applying logical consequences requires two philosophical steps. The first is to help the youths reach the level of "ownership," or accepting that the problem is theirs. The second step is to have them learn good decision making by looking at the consequences of their decisions, both for themselves and for others. Neither step is easy. The first step, for example, is confounded by the habitual stance of the violent juvenile offender of projecting blame for his behavior. As Yochelson and Samenow (1976) describe the thinking pattern, they display the "victim stance" whenever they are caught at some misbehavior. That is, they claim that they themselves are the victim of the behavior. They usually have long histories of having been rewarded for not "owning" their behavior by having consequences removed or lightened.

Regarding the second step, character disorders are renowned for their so-called "inability to learn from experience." Whatever the source of this behavior, it is seen in an enormous resistance to even attempting behavioral alternatives to their usual aggressive, harmful behavior. For this reason, the discipline has to be structured enough to be resistant to strong attempts to manipulate, intimidate, or escape from the consequences in the program.

At the same time, the system has to do this without inhumane consequences, and in fact with less acceptable consequences than the typical family is allowed.

The programs that are successfully treating violent juvenile offenders have mastered the ability to control negative behavior and also, in the majority of cases, to have youths learn to discipline themselves.

Specialized Treatment for the Juvenile Sex Offender

As stated in the section on program descriptions, most treatment programs for the violent juvenile offender, whether or not they mix offense groups, have portions of the program specifically directed toward the sexual problems of the juvenile sex offender. Knopp (1982) summarizes the components of most of the programs for sex offenders as follows:

> Presently, program components include *family therapy*; various types of *education in human sexuality*, sometimes for the entire family; *victim awareness* exercises, including empathy training, accountability and responsibility acceptance, and familiarity with cycles of victimization; *interpersonal social skills development*, which teaches communication, socialization, and group work; *anger management*, which deals with conflict resolution and negotiating skills; *grief work*, which helps work through personal victimization and trauma; *journal keeping*, which teaches how to record thought processes and fantasies and encourages writing autobiographical materials; *survival skills*, which include stop-thought processes and day-to-day living skills; *sex-role expectations*, which educate about "macho" sex-role stereotyping; and *general education*, which includes a high school diploma and vocational and occupational therapies. Some programs also have *alcohol dependency groups* or refer adolescents to community self-help groups for chemical dependents. Programs increase in structure and intensity in line with the seriousness of the offense and violence exhibited by the offender. (p. 37)

Lane and Zamora (1984) describe five fairly distinct phases of their treatment of juvenile sex offenders. They are: (a) penetrating the denial and dealing with the sexual assaults the youths committed; (b) identifying the individual's rape cycle and working with the daily manifestations of the cycle; (c) working with unresolved emotional issues (particularly their own victimization if they were sexually abused in early childhood); (d) retraining in the areas of skill deficits; and (e) reentry into the community.

Because treatment of the juvenile sex offender is in a developing phase, as is the treatment of the violent offender in general, most programs only have tentative data about their effectiveness. However, the results to date show a great deal of promise in the ability to successfully intervene in the sex offender's behavior in adolescence.

A Secure Setting and Adequate Time for Treatment

Although the degree of security varies in different programs, it is generally accepted that violent juvenile offenders must be treated in secure settings. The basic reason for this is for the protection of the community. Most violent delinquents have developed a pattern under pressure to escape if at all possible, and they, of course, experience considerable pressure in most successful treatment programs. Again, unlike the nurturing, protective environment of traditional mental health programs, the programs for the violent juvenile offenders are confrontive, structured, and emphasize consequences for irresponsible behavior. The pressure of critically examining their behavior and changing is likely to make life fairly uncomfortable for the violent juvenile offender, and increase attempts to return to their previous lives full of criminal excitement. Many programs that did not actively attempt to prevent escapes were eventually terminated due to backlash from the general

public and their lawmakers. In treating the violent delinquent, staff must realize that their top priority is to ensure the safety of the community.

In addition, successful treatment of the violent juvenile offender is not possible in short-term settings. Unfortunately, many earlier attempts at treatment failed because the violent offender was not kept in the program long enough to see if surface behavior changes would last over time. This was contributed to both because of the pressure of space problems and also because of the philosophy that short-term treatment is the best choice for any client population. Unfortunately, most violent juvenile offenders become quite "psychologically sophisticated" over their careers in various treatment settings, so they often are successful at pretending to "go along with program" and experience great insight until staff feels they are ready for release. Another common tactic is to intimidate or act out enough that staff will release, transfer, or allow them to escape. The result, of course, is that the violent offender is left with the feeling that once again he or she has "beaten the system."

It is impossible to define what enough time is, of course, as it varies with each individual. In ideal programs, the treatment program is designed with a level system wherein the youth earns increased freedom along with increased responsibility, and is unable to leave the program until his or her behavior has improved and maintained over enough time that the changes appear to be permanent. Testing the youth with a slow transition period into the community is also a part of the ideal program. Again, violent offenders with long offense histories are highly unlikely to really benefit from short-term intervention.

PROGRAM DEVELOPMENT EFFORTS

Although the statistics indicate a "leveling off" in the incidence of violent juvenile crime, the leveling off is at a level much too high for community safety. As Heide (1979) indicated in her study of adolescent arrests for murder and non-negligent homicide in the United States, between 1960 and 1975, such crimes increased more than 200%. As summarized by Empey (1979) and Isralowitz (1979), there is a growing disenchantment with the juvenile justice systems, and rapidly increasing tendencies to send dangerous juveniles to adult correctional settings. Fortunately, the experts in juvenile corrections are strongly resisting this move and generally are using what meager resources most have to develop long-term, intensive, secure treatment programs for violent juvenile offenders within the juvenile system. Numerous states and provinces in Canada are in the process of developing treatment programs specifically for this population. Notable at this current time are the states of Utah, New Mexico, Michigan, and Mississippi, whose programs for the violent offender are in the initial stages after long and intensive planning. Many other states are in the planning process, or already have some capacity to treat the violent juvenile offender. It is clear to experts in the field that intensive treatment efforts are far preferable in most cases to sending a youth to an adult custodial setting.

REFERENCES

Agee, V. (1979). *Treatment of the violent incorrigible adolescent*. Lexington, MA: Lexington Books.

Agee, V., & McWilliams, B. (1984). The role of group therapy and the therapeutic community in treating the violent juvenile offender. In R. Mathias (Ed.), *Violent juvenile offenders: An anthology*. Newark, NJ: National Council on Crime and Delinquency.

Dreikurs, R., & Grey, L. (1970). *A parent's guide to child discipline*. New York: Hawthorne Books, Inc.

Empey, L.T. (Ed.). (1979). *The future of childhood and juvenile justice*. Charlottesville, VA: University Press of Virginia.

Gadow, D., & McKibbon, J. (1984). Discipline and the institutionalized violent delinquent. In R. Mathias (Ed.), *Violent juvenile offenders: An anthology*. Newark, NJ: National Council on Crime and Delinquency.

Glasser, W. (1965). *Reality therapy*. New York: Harper & Rowe.

Glasser, W. (1981). *Stations of the mind*. New York: Harper & Rowe.

Heide, F. (1979). Juvenile justice: The second revolution. *Crime and Delinquency, 25*, 299–318.

Isralowitz, R.E. (1979). Deinstitutionalization and the serious juvenile offender. *Juvenile and Family Court Journal, 30*, 21–35.

Jones, M. (1953). *The therapeutic community*. New York: Basic Books.

Knopp, F.H. (1982). *Remedial intervention in adolescent sex offenses: Nine program descriptions*. Syracuse, NY: Safer Society Press.

Lane, S., & Zamora, P. (1984). A method for treating the adolescent sex offender. In R. Mathias (Ed.), *Violent juvenile offenders: An anthology*. Newark, NJ: National Council on Crime and Delinquency.

Miller, R.B., & Kenney, E. (1966). Adolescent delinquency and the myth of hospital treatment. *Crime and Delinquency, 12*, 38–48.

Sacks, M., & Carpenter, W. (1974, May). The pseudotherapeutic community: An examination of antitherapeutic forces on psychiatric units. *Hospital and Community Psychiatry, 25*, 315–318.

Silber, D.E. (1974). Controversy concerning the criminal justice system and its implications for the role of mental health workers. *American Psychologist, 29*, 239–244.

Tennenbaum, D.J. (1978). Dangerousness within a juvenile institution. *Journal of Criminal Justice, 6*, 329–345.

Vorrath, H., & Brentro, L.K. (1974). *Positive peer culture*. Chicago: Aldine Publishing Company.

Warren, M. (1983). Applications of interpersonal maturity theory to offender populations. In W. Laufer & J. Day (Eds.), *Personality theory, moral development and criminal behavior* (pp. 23–164). Lexington, MA: Lexington Books.

Weeks, H.A. (1958). *Youthful offenders at Highfields*. Ann Arbor: The University of Michigan Press.

Yochelson, S., & Samenow, S. (1976). *The criminal personality, Vol. 1, A profile for change*. New York: Jason Aronson.

Yochelson, S., & Samenow, S. (1977). *The criminal personality, Vol. 2, The change process*. New York: Jason Aronson.

PERGAMON GENERAL PSYCHOLOGY SERIES
EDITORS
Arnold P. Goldstein, *Syracuse University*
Leonard Krasner, *SUNY at Stony Brook*

YOUTH VIOLENCE
PROGRAMS & PROSPECTS

edited by
Steven J. Apter
Arnold P. Goldstein
Syracuse University

Sponsored by
the Begun Institute and
the Society for the Prevention of Violence
Cleveland, Ohio

PERGAMON PRESS 1986
New York Oxford Toronto Sydney Frankfurt