A Residential Treatment Center’s Integrative Approach

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The Jerusalem Hills Children’s Home is a unique, psychoanalytically oriented therapeutic centre where 95 children with severe emotional problems are treated. The children are referred by the Ministry of Welfare after being removed from their homes where many of them suffer from neglect and sexual abuse. Due to their severe pathology, the treatment of choice for these children is our Residential Treatment Method (Cohen, 1998) where object relations evolve in a potential space (Winnicott, 1953, 1971), which enables exploration of the child's inner world, projections and mental processes.

Psychoanalysts and psychoanalytically informed psychotherapists work with the children and their families. They also instruct and train the staff members who work directly with the children, guiding them as they establish their relationships with the children as the basis for treating them.

Our intervention program for the treatment of severely damaged children with deviant sexual behaviours is based on several equally important and interdependent components:

- Psychoanalytic psychotherapy – two sessions a week.
- Psycho-educationally oriented weekly individual meetings with a caregiver. The focus of these meetings is the child's deviant sexual behaviour.
- Sex education group work as part of the school program. The teachers conduct group sessions on different topics relating to sexual development and normative behaviour.

Together these components present a comprehensive model of treatment. I shall revisit this point after sharing with you our thought processes when deciding to initiate this program.

Until recently most approaches were ‘absolute truth’ theories, each approach claiming exclusivity concerning the ‘right’ way to treat children who were exposed to sexual abuse. There were those who claimed that only explicit group interventions, (separate groups for offenders and victims) were effective, others supported cognitive behavioural interventions, dealing mostly with ‘here and now’ issues and not engaging with the patient’s past as a means of changing deviant sexual behaviour and the obsessive thoughts accompanying it.

In our children’s home we practice the dynamic approach, which addresses sexual behaviour as part of the child’s disorder as a whole and, like other parts of the personality, can be treated in the context of psychoanalytic psychotherapy and the residential treatment approach without having to add any special focus on the sexual abuse.

Among those who consider psychoanalytic psychotherapy as the major method of treatment there are therapists who emphasise the aspect of trauma while others focus on the specific developmental aspects of each child.

Recently this approach has been modified, both in the literature and in the field, towards a more integrative technique (Woods, 2003). It seems that when offering an integrative treatment which includes group therapy, educational interventions in the life space, cognitive behavioural treatment,

and psychoanalytically oriented psychotherapy the results are significantly improved. Our experience validates this point.

We are uniquely able to provide this comprehensive program in our residential home since we have both a school on campus as well as residential facilities. We also have the necessary psychoanalysts and psychoanalytically oriented therapists on staff who can provide supervision to the direct staff members involved in the program. Programs that take place in the community cannot offer this integrative approach nor can they provide the professional accompaniment as we do.

In our residential treatment centre we recognized that there are children who require the addition of an educational approach after identifying some uncompromising symptoms that appeared in everyday life space but had no manifestation in therapy (for example ‘adhesive’ behaviour with sexual nuances, obsessive thoughts about sex). In therapy the issues are addressed through the perspective of the child’s inner world and mental processes and do not necessarily offer immediate relief or change in the life space.

However, not all the children in our care require this form of integrative substantial treatment regarding sexuality. We have determined several symptoms that serve as guidelines for participation in this program. They are:

- Adhesive bodily behaviour with sexual nuances – including inappropriate hugging and touching which arouses (in the countertransference) a general feeling that intimacy and contact are not pleasant but instead intrusive and sexual. It is common that this behaviour is accompanied by inappropriate bodily movements (such as seductive pelvic movements). I would like to point out that this is not about undifferentiation, which can be observed in children with severe developmental arrest, who have not achieved separation and individuation and experience the object as an extension of themselves. In the latter case we do not expect to experience sexual feelings.
- Sexual assaults – children who enter other children’s beds at night seeking sexual contact, touch other children in intimate places (with or without clothes), initiate sexual contact or oral sex.
- Obsessive and indistinct verbalization of the sexual abuse with any adult that is randomly present – children who talk about what they have gone through without noticing with whom they are talking, when and where. The feeling is that the child is living the trauma and overwhelmed by the experience.
- Arousing uneasiness when in contact with an adult – seductive and repulsive in bodily movements and speech.
- Inappropriate and indistinct talk with other children when referring to sexual matters – complete chaos regarding the topic of sex, no differentiation (between sexes, generations, what is appropriate and what is not). Children who might have been exposed to sexual activity, pornography, or mutual experiences with their parents.
- Obsessive and disturbing thoughts about sex and sexuality – they can’t seem to stop these thoughts, even if they manage not to verbalize them.
- Seemingly no symptoms – children whose background material indicates clearly that they have been sexually abused or been sexual offenders, children who have revealed such information during treatment with us but in everyday life, there is no trace of these events. There is no feeling of unease or inappropriateness in contact with adults or other children.

As mentioned previously, this program does not create instant changes in behaviour and relations

because we are treating severely damaged children, therefore in extreme cases it may also be necessary to apply a physical protection program which includes linking the child to an adult so that he can be protected and physically separating children who have had inappropriate sexual contact.

A case study

In the case of Nadav who came to the residential treatment centre with the ‘label’ of a sexual offender, there were no signs of deviant sexual behaviour in everyday life. Nadav belonged to the category of children who seemingly show no symptoms. There was a vague notion concerning sexual abuse at home related to his father. It was not certain who was harmed. On the one hand, Nadav invested considerable energy concealing and denying the matter. On the other hand, in the psychotherapy sessions he was overwhelmed with sexuality merged with aggression, as was explicit from the first session on.

Unlike the reality-based situations in school and in the group setting where the primitive defence mechanisms (such as denial and repression) were effective, in the vague environment of therapy, these mechanisms did not work. The potential space created in therapy evoked immediate projections regarding the therapist based on an internalized archaic female figure. In this undefined, vague situation Nadav became anxious as he felt exposed to content that rose from his inner world. The default reaction was to reconstruct his primary and familiar relationship in which primary desires and seduction were intertwined. A state of being that his therapist referred to as a ‘mental cage’.

The therapeutic process that took place in psychotherapy sessions enabled Nadav to internalize a ‘new object’ (Loewald, 1979), a new female object, alongside the archaic female figure that existed in his inner world. The archaic female figure was, as described by the therapist ‘unconsciously experienced as weak prey, helpless when encountered with the violent passionate male predator’. The relationship cautiously established by the therapist introduced Nadav to a new feminine figure that he could experience a non-seductive relationship with. A strong female figure who preserved proper boundaries and generational differences. Within this relationship it was possible to express primary desires without becoming seductive. Due to the boundaries and order in the inner world achieved in therapy it became legitimate for him to express sexual curiosity and desires appropriate for his age without feeling embarrassed.

It is difficult to imagine this impressive process in the therapeutic relationship taking place without the crucial attendant processes of the group work conducted by his teacher in the reality of the classroom and the individual meetings with his caregiver in the group living setting.

The group work in the school setting enabled the legitimacy of age-appropriate thoughts and curiosity relating to sexuality, previously experienced in a confused and shame inducing manner. Gradually, Nadav could experience a reduced amount of guilt and embarrassment and could benefit from the discussion in the group. It seemed that he could also begin to gradually let down his primitive defenses and be further in touch with sexuality in general and specifically with his own sexuality. This was also possible owing to the process that evolved at the same time in psychotherapy where making order out of the chaotic inner world reduced the anxiety level in connection with sexuality and enabled Nadav to differentiate between wishes and what is appropriate. Also, the opportunity to experience a relationship with a woman that is not seductive and sets boundaries in the relationship enabled Nadav to modify his concept of the relationship between couples, as he expressed in the group meeting. Quoting his teacher: ... ‘I felt a direction of new thoughts opening for Nadav, different from his usual one’ (perhaps weakening the ‘mental cage’?).

The individual work with Nadav's caregiver provided the possibility to talk about events that took place at home, although it was difficult for him to express his feelings and thoughts about the upsetting situations he described. The emotions brought up were then worked through in psychotherapy. It is difficult to expect a child with such primitive and rigid defenses to perform differently, although there was clearly a breakthrough in terms of the image he presented in the life space. In the caregiver's words: the walls still existed but there were cracks out of which sexuality leaked. The fact that the individual work with the caregiver was based on reality and an educational approach could have hindered the possibility of expressing more emotions, but it served as an advantage when the caregiver intervened when Nadav was involved in inappropriate sexual behavior in his group. The caregiver's intervention was experienced by Nadav as a benevolent parental position, made possible by the relationship established in the individual sessions. It might have been experienced as a punitive or revengeful position had there not been such a relationship in place and the caregiver's intervention would have not been effective.

In psychotherapy Nadav's primitive and rigid defenses were not effective, producing chaos, powerful projections of sexuality and aggression merged in a pathologic manner and high levels of anxiety. In order to be able to perform the therapeutic tasks, working with his inner world, it is vital that a child feels embraced and secure. This is only achieved with the help of teachers and group workers who are responsible for the child's wellbeing in the life space. Psychotherapy enabled Nadav to internalize a new female figure which modified his perception of sexuality and his own sexual behavior.

In conclusion, it is clear that there is a need for each of these types of interventions and the complimentary relationship between them is a successful model for treatment.

References

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