

President's Corner – John Santa, PhD

Rapid Growth in Response to Adolescent Need and Failure of Traditional Care

I am writing this as the first in a series of columns from the President's Desk. In this column I will address current topics and hopefully establish a tradition in which each President of NATSAP regularly contributes his or her thoughts. In this first column I will address some of the factors that have contributed to the recent rapid growth in our field, and I will reflect briefly on the fear and scrutiny that has accompanied this growth.

NATSAP began seven years ago with seven founding member programs. Within a year we had over sixty programs, and we now number more than one hundred and fifty member programs. When one looks back at when our member programs were themselves founded, we see a picture of escalating growth.

Decade	1900	1910	1920	1930	1940	1950	1960	1970	1980	1990	2000-2005
# of Programs founded	1	0	1	3	0	2	3	8	26	53	57

Extrapolating from these figures we could expect 100 new programs in the first decade of the second millennium, or a doubling of the number of programs every ten years. Another way to summarize the growth is to note that 2/3 of all NATSAP programs have been founded in the past 15 years.

A number of economic, cultural, and social factors have escalated the demand for the growth of our unique level of care. Considering economic factors first, an affluent society makes it possible for a larger number of families to afford private care for their children. We have also seen a general increase in materialism and parental indulgence over the past three decades and an accompanying decrease in structure to contain adolescents as they grow up. Structure and authority have eroded within families and across the culture. Routines have broken down with fewer commitments for family traditions and occasions that establish solidity in the family. Our cultural and family values have blurred and become diluted. Children no longer have a clear, and properly subordinate role in a family. The pace of our culture, coupled with busy, distracted, and often divorced parents has increased stress and pressure on both adults and children.

Corresponding with the deterioration of cultural containment is an increase in the potency of drugs readily accessible to much younger children. The increased availability of drugs is a natural response to a pressured culture lacking adequate structure. The drugs offer relief, escape, and a false sense of maturity.

Children struggle to keep pace without a net of safety and containment and rapidly fall behind in genuine maturity. These children fall behind in broad ways. They lack impulse control and have difficulty modulating their feelings and delaying gratification. They lack the foresight and ability to plan for the future in realistic ways and the moral compass of an appropriately mature young adult.

These adolescents are not bad kids, or sick kids, but grossly undeveloped and immature children who approach the world in a manner expected and tolerable from a much younger child. Emotional infants are asked to face the challenge of preschool. Emotional toddlers are asked to sit quietly and behave in the elementary years, and emotional first graders are expected to sustain attention, delay gratification, and focus on content and future goals in high school.

My business partner John McKinnon, M.D. and I believe that most of our residential programs are designed to assist students in growing up, maturing, and developing a view of themselves more congruent with the tasks required of a successful adolescent. We all work with students who have obtained numerous DSM-IV AXIS I psychiatric diagnoses, but for the most part these symptom clusters represent superficial manifestations of the broader problem of delayed maturation of their personality structure. Our students' problems would in fact be better described by a missing part of the diagnostic system, namely a description of difficulties encountered by adolescents who are in the process of forming a stable personality structure.

The factors I have just outlined partially explain why we have an increased demand for services, but they do not explain why the rapid development of successful, largely privately owned, residential programs. Why wasn't the need met by our vast array of treatment services and options including local psychiatric hospitals, outpatient psychiatrists, therapists, and public school systems? Why do families seek out and pay privately for longer term residential placements in our programs?

The short answer is that our society has exhibited a massive failure to recognize the nature of the problem and has misallocated resources in order to control symptoms rather than addressing the real problem, which is a lack of personality development in our youth.

In contrast, most of our programs are designed specifically to help children mature by creating safe environments, predictable structure, and accountability. For children to grow internally and not simply superficially, they also need accurate recognition and understanding in the context of meaningful relationships, i.e. good therapy. These simple but not easily implemented ingredients have been neglected and even reduced in traditional psychiatric care. The emphasis has been on managing costs and controlling symptoms by shifting the level of care downward. The presumed rationale is that it will be helpful to “return patients to the mainstream as quickly as possible.” With cost control in mind, length of stay in psychiatric hospitals has decreased dramatically in the past two decades. Management of symptoms with medication has exhibited a corresponding rapid increase. Obviously, medications can be effective in helping to regulate the DSM-IV AXIS I problems. I am certain that medication and outpatient management has assisted many adolescents in returning to an appropriate level of developmental function. They go along with the rules, they remain successful in school, and regulate emotions and interpersonal relationships in reasonably healthy and effective ways.

However, many others simply do not respond to medication and symptom management and continue to exhibit global developmental failure. These failures from conventional managed care treatment form the basis for our rapidly growing and thriving profession. These children need containment in a nurturing environment that includes appropriate limit setting and accurate recognition. These factors, over time, propel personality development and restructuring and provide the kind of treatment that can address the true problems faced by our struggling adolescents.

Turning to education, both public schools and private boarding schools have also failed to understand or meet the problem of developmentally delayed adolescents. Conventional schools, particularly past the fourth grade, focus instruction on content and presume that both society and parents are on the job attending to emotional needs. School administrators and teachers feel increasingly intimidated by both parents and child advocacy groups about setting limit, or in demanding emotional and behavioral accountability. A generation ago a teacher’s authority was nearly absolute and rarely challenged openly by either students or their parents. Also, schools have limited control over a student’s environment and too little co-operation with parents to create a safe holding structure with clear limit setting. Often schools must resort to setting ultimate limits by removing a child from school rather than having an array of responses available to help children face and work through their problems.

Many children in our schools and programs have failed miserably at conventional education and have embedded this failure as part of a self concept. They begin to believe that they are stupid, learning disabled, dyslexic, attention deficit, or oppositional defiant -- in short, defective individuals. Students with such self attributions and loathing tend to withdraw from school, fail to work to capacity, and avoid the very arena that brings forth these feelings of failure. Most schools, both public and private are simply not equipped, designed, or funded to address the whole development of a child.

It is not surprising that private enterprise (NATSAP programs) has responded with creative solutions to the failures of traditional psychiatric care and education. Our programs have responded to the crises our youngsters face by recognizing the need to remove them from toxic environments. They have recognized the need to treat the whole child in safe, contained environments that allow the time, feedback, and structure required to develop a more functional personality structure. Again, these children need to mature internally as opposed to simply managing their symptoms. It is this real need for a new continuum of care that has provided the impetus for such rapid growth in our programs.

Of course, such rapid growth and the emergence of a new continuum of care has led to many fears and much criticism. Media coverage paints a picture of rampant profiteering, abuse, and neglect in our programs coupled with a cry for more regulation. Organizations have formed, protesting institutional abuse of children and complaining about the lack of regulation of wilderness programs and therapeutic schools. They have circulated petitions and called for national regulation of residential programs (e.g. the legislation proposed by Rep Miller, CA).

Now, more than ever, we need NATSAP as a national organization and voice to educate the public and political constituencies about our programs. As individual programs we can’t be complacent. We must become even more involved in NATSAP’s effort to raise the bar on practice standards. We must educate legislators and the public by inviting them to visit our programs and help them understand how our programs meet the needs of adolescents who lag in emotional development. Each of us must explain our approach to helping adolescents, and why we need this new continuum of care.

As a national organization we have established consensus concerning the most effective and appropriate practice standards. NATSAP provides a professional and learning community that will be far more effective in raising practice standards than governmental regulation designed by those not belonging to our profession. In situations where regulation is required, members of NATSAP must be included in creating the regulations. After all, we are the professionals and the entrepreneurs who know how to make our programs even better than they are now.

John Santa, Ph.D. is a founding board member of NATSAP, and currently President of the Association. He is a clinical psychologist, a co-founder and clinical director of Montana Academy, a therapeutic boarding school.