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OVERVIEW

It all comes down to how we care about each other! Interpersonal exchanges are organized by the perspectives and experiences we bring to relationships. From developmental science comes trauma-informed care. The articles in this volume report that trauma-informed care fundamentally changes the way we interact with children and youth by recognizing not only who they are, but what they have been through. Complex and challenging behaviors, generated in response to our attempts to help, are the product of past abuse. Understanding this developmental dynamic provides a deep sense for "why and how" to support healthy change.

In addition, through trauma-informed care, we break new ground in recognizing that telling the story of the abuse may be less a one-time response to crisis but more a life-long opportunity to tell the story over time in ways that evolve as healthy gains. Could it really be as simple and complex that with the right love and care, children and youth build an emotional and psychological reservoir of positive experiences that will always be tested based on the past, but ultimately can come to be trusted as the new story? This is the main theme which the articles in this volume communicate through program and practice.

In transformation, children and youth are more anxious than not to regain safe control over their lives. They can seek a false sense of control in negative acting out if left in situations which continually lack appropriate supports. On the other hand, through active and effective youth-adult partnerships, youth can counter the effects of trauma by gaining repeated "normalized experiences" by taking healthy risks. Trauma-informed care provides the tools and techniques for youth to translate repeated positive experience into the skills necessary to manage everyday life experiences and ultimately to become architects of their own lives.

None of us really like the term "normalized," but normal is a concept that the public and the policy makers can understand. With trauma-informed care has come the clarion call for all youth, especially youth who have been sorely abused in life and by the welfare system, to have the normal experiences needed to grow up in a healthy way. In best practice, we are therefore rapidly moving away from systems that re-traumatize children and youth to initiatives that keep kids as connected as they can be to families and community.

Gone is the notion that they should be removed from society for their own protection or even to be consequented. And instead we have replaced the old thinking with a trauma-informed care approach that demands that every young person have the opportunity and access to strength-based, everyday life, growing up activities. A foster youth should be able to have an overnight and go to the prom. A youth in a group home should be able to go to after-school the same way the other youth in class do. Youth in detention centers deserve the chance to rehabilitate through career preparation. These age-appropriate everyday life activities are the sustenance for the possibility of lifelong success at school, home, and work.

How could these things somehow have been lost or fallen out of focus for our young people; they make so much intuitive and moral sense? Famously, Professor Vander Ven is known for saying "we become what we do!" The trauma-informed care commitment is to reduce risk and increase protection by providing normalizing experiences that result in the redefinition of permanence as a large network of relationships to support our youth in times of concrete needs. In this network of relationships, youth master skills and competencies through the positive experience of healthy interdependence.

The new neuroscience powerfully validates this approach. It turns out that while zero to three or five is a critical period for healthy development, so too is adolescence through early adulthood. The brain is still forming into the 20s and the executive decision-making function of the brain forms last. Now we know that youth who get the right nutrition, love, support, and developmental activities—even late in life—are likely to form the necessary pathways in the brain that structure healthy and positive behavior!

This edition of the *Journal of Child and Youth Care Work* sounds these themes and provides a rich portrait for the evolving strengths of trauma-informed care across practice settings of our field; from program informed by policy to the most recent advances in direct care tools and techniques. Experts from across a full range of professional disciplines served as a review panel for the proposed articles:

Joseph Benamati, *Ph.D., Senior Faculty,* Sanctuary Institute, Yonkers, New York

Charlyn Harper Browne, *Ph.D., Senior Associate* and *Director of Quality Improvement Center on Early Childhood,*
Center for the Study of Social Policy, Washington, DC

Rachel Burke, Jim Casey Youth Opportunities Initiative

Patrick Foran, *BA, Director and Coordinator,* Hull Services,
Calgary, Alberta, Canada

Adrian Hawkins, Jim Casey Youth Opportunities Initiative

James Henry, *Ph.D., Associate Professor,* Western Michigan University,
Kalamazoo, Michigan

Frank Kros, *MSW, JD, President,* The Upside Down Organization and
Executive Vice President of The Children's Guild, Baltimore, Maryland

We were particularly pleased and learned a great deal from the youth leaders who joined fully in the expert panel from the Jim Casey Youth Opportunities Initiative. Full and authentic youth engagement with youth represents the future.

For the better part of the past fifty years, the *Journal of Child and Youth Care Work* has often debuted new models for practice. The most powerful evidence is drawn from our work, up front and close with the children and youth, in the professional practice of direct care. Such contributions, for example, reach back to Jack McElroy's notions of the power of attachment in a "children's garden of relationships" and Mark Krueger's practices of "grounded rhythm and presence." In the same way attachment and relationship have stood the best test of time, we believe that trauma-informed care will change the trajectory for the depth and sustainability of child and youth care work.

Among the contributions presented, from the team at the Center for the Study of Social Policy (CSSP), comes an article on Youth Thrive. Youth Thrive is a dynamic national initiative to reduce risk and increase protection by delivering trauma-informed care. The editors would like to note that some of this material has appeared previously on *www.cssp.org*, which provides a download for a comprehensive review of the literatures which support trauma-informed care: *Advancing Healthy Development and Well-Being* by Dr. Charlyn Harper-Browne.

Also, on the Jim Casey Youth Opportunities Initiative website, *www.jimcaseyyouth.org*, is the *Adolescent Brain: New Research and Its Implications for Young People Transitioning From Foster Care*. This download comes complete with evidence-based research, executive summary, and PowerPoints for transferring the knowledge.

In addition to the trauma-informed care theme, this edition also has a "special invited section" designed by Professor Karen Vander Ven, past editor of this journal, on the work of Erik Erikson. Erikson, who taught in the program at the University of Pittsburgh that prepared child and youth care workers, was among the first to fully understand the historical moment for young people that is produced when the trauma of conflicts can be resolved. We mature through the life cycle. It could be said that the work of childhood is play and the work of adolescence is intimacy. The articles in this invited section explore the work of child and youth development with a lens toward how important it is in trauma-informed care to understand the way in which we resolve conflicts through relationships, opening the door to the mastery of developmental competencies.

The editors would also like to note that this section has the last published work of Peter Benson, completed just before he passed away. Dr. Benson led Search Institute, which ultimately delivered developmental assets in more than 650 communities across the country and around the world. He was the seminal author of *All Our Kids* and believed deeply in developmentally-attentive community. The worst trauma in the life of any young person was the lack of an adult who cared and the greatest strength was the asset of youth in partnership with many, many adults. The signature theme for the goal of the developmental asset movement launched

by Peter was "healthy youth and healthy community." Adieu, Peter, we won't forget your work. Let us all live up to Peter's greatest hope!

Finally, this issue includes two additional peer-reviewed articles: one focusing on the role for youth workers in providing mental health care, and the second exploring the impact of rural youth services on education, housing, and employment outcomes.

Andrew J. Schneider-Muñoz, *Editor*
Dale Curry, *Co-Editor*
Jean Carpenter-Williams, *Managing Editor*

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TRAUMA-INFORMED CARE: AN ECOLOGICAL RESPONSE

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Exposure to traumatic stress is increasingly understood as a common denominator of children and youth across service systems. Unlike the usual stresses of our daily lives, traumatic experiences occur outside the realm of usual experience, threaten one's life or bodily integrity, and invoke intense feelings of helplessness, powerlessness, and terror (American Psychological Association, 2008). These events "overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning" (Herman, 1992).

Exposure to traumatic experience is common for children and adolescents across service systems. For example, in community samples, more than two-thirds of children report experiencing a traumatic event by age 16 (Copeland, Keeler, Angold, & Costello, 2007). One in four children attending school have been exposed to a traumatic event (National Child Traumatic Stress Network Schools Committee, 2008), and over 80% of children and youth who live in dangerous neighborhoods have experienced trauma (National Center for Children in Poverty, 2007). Interpersonal violence is one of the most common forms of traumatic stress for children and youth. Based on the National Survey of Children's Exposure to Violence (NatSCEV), 38% of children and youth ages 2–17 reported more than one type of direct victimization in the previous year, and nearly half (49%) suffered two or more types of direct or indirect victimization (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009).

Advances in the neurological and developmental sciences have brought an explosion of evidence demonstrating the devastating, long-term impact of traumatic stress on the developing brain and body (Center on the Developing Child at Harvard University, 2010; Felitti et al., 1998; Felitti & Anda, 2010; Shonkoff et al., 2012a, 2012b; Shonkoff & Phillips, 2000; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). As severe stresses and traumatic events accumulate, the physiological and psychological impact becomes more profound, resulting in a range of adverse responses including neurobiological changes, difficulties regulating affect, and problems forming supportive relationships (Cook et al, 2005; National Scientific Council on the Developing Child, 2005; van der Kolk et al., 2005). As a result, many survivors of trauma suffer the debilitating consequences for the remainder of their lives.

Historically, health and human service systems have served people who have experienced trauma without understanding its impact and the need for tailored

responses (Harris & Fallot, 2001). However, as the science of traumatic stress has evolved, it can no longer be ignored in public systems of care. This recognition has galvanized a cross-sector call to action, from the local to federal levels, to adopt trauma-informed care as a practice across service settings (Report of the Federal Partners Committee on Women and Trauma, 2011).

Trauma-informed care represents an emerging shift in paradigm and practice. An ecological approach, trauma-informed care can be viewed as a universal design for serving trauma survivors; the entire system is used as a vehicle for intervention (Bloom, 1997; Clervil & DeCandia, 2013; Guarino et al., 2009; Guarino, 2014; Harris & Fallot, 2001; Hopper, Bassuk, & Olivet, 2010; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014). Trauma-informed care is a "strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma that emphasizes physical, psychological, and emotional safety for both providers and survivors; and creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper, Bassuk, & Olivet, 2010, p. 82). Accomplishing this requires a commitment and a coordinated effort at all levels—federal, state, and local—to changing the practices, policies, and cultures of entire organizations within and across systems, using knowledge of trauma and recovery to design and deliver services (Guarino et al., 2009; Guarino, 2012).

This article provides a comprehensive review of trauma-informed care—its evolution, current models and practice, and evidence base. First, we discuss the contextual factors underlying this paradigm shift. Next, we review the current state of the field, and lastly, we conclude with a discussion of research, policy, and practice implications. We pose the following questions: Is the field ready to embrace this paradigm and respond with a new perspective and practice? How can the pitfalls of the past be avoided? What will it take to build and sustain a truly trauma-informed system of care?

The Evolution of Trauma-Informed Care

As a society, we have a long history of alternately denying and prioritizing traumatic stress as a cause of suffering (Bloom, 2000; Herman, 1992; McFarlane, 2000; Ringel, 2012). When denied, the paradigm of individual responsibility and individual pathology leading to a "blame the victim" mentality prevails; when prioritized, social context and the impact of environment, experience, and relationships on human development are seen as central to the cause of, and solution to, human suffering. In her book, Trauma and Recovery, Herman (1992) writes, "The study of psychological trauma has a curious history . . . Periods of active investigation have alternated with periods of oblivion. Repeatedly, in the past century, similar lines of inquiry have been taken up and abruptly abandoned, only to be rediscovered much later . . . It [the field] has been periodically forgotten and must be periodically reclaimed" (p. 7).

Why does this occur? To study or treat those affected by traumatic stress demands engaging with the reality and magnitude of violence and abuse in our society. Often the feelings associated with this reality are too much to bear (Ringel, 2012). "The larger society will continue to deny the magnitude of the problem, not only because of the emotional arousal exposure causes, but also because it is becoming increasingly clear that fixing the problems and actually preventing trauma will cost a great deal" (Bloom, 2000, p. 45). Denial allows us to distance ourselves from the feelings and moral obligations to act; the consequence is that pathology and intervention are situated within the individual rather than the social realm (Bloom, 2000; Herman, 1992; McFarlane, 2000).

Shifts in society's consciousness about trauma often occur following periods of war (Herman, 1992; McFarlane, 2000; Ringel, 2012; Terr, 1990) and when supported by social, humanitarian, and political movements (Bloom, 2000). For example, the acceptance of posttraumatic stress disorder (PTSD) in the Diagnostic and Statistical Manual-III in 1980 was preceded by almost two decades of cultural and political movements focused on civil rights, as well as the ending of the Vietnam era that for the first time graphically televised the trauma of war to the American public. This period supported the reemergence of the study of traumatic stress among veterans and linked it to the trauma of rape survivors and child abuse (Benedek & Ursano, 2009; Bloom, 2000; Figley, 2002; Kramer & Greene, 1997; McFarlane, 2001; SAMHSA, 2014).

The current sociopolitical climate, including post-9/11 and military actions Operation Iraqi Freedom and Operation Enduring Freedom, combined with the mounting neurodevelopmental research on the prevalence and impact of trauma, and the recognition of the social determinants of health (e.g., family and community factors), have created a context ripe for further evolution of the trauma field. Traumatic stress is once again being viewed as central to the problems of those served by our health and human service systems, and ecological responses that can be brought to scale are gaining favor. This context has begun to unite policymakers, researchers, and service providers, setting the stage for the current paradigm shift to trauma-informed care (Report of the Federal Partners Committee on Women and Trauma, 2011; SAMHSA, 2014).

Awareness of Violence and Trauma in the Lives of Children, Youth, and Families

Over the past two decades, researchers have documented the prevalence of trauma in the lives of children and youth across service sectors; the staggering numbers are impossible to ignore. For the nearly 500,000 children in the foster care system (U.S. Department of Health and Human Services, 2012), traumatic experiences include abuse, neglect, and significant family stressors (Stukes Chipungu & Bent-Goodley, 2004). In the juvenile justice system, up to 90% of youth reported having experienced at least one traumatic event (Ford, Hartman, Hawke,

& Chapman, 2008). Of psychiatrically hospitalized adolescents, 93% have histories of physical or sexual and emotional trauma (Lipschitz et al., 1999). In addition, children in the homeless service system demonstrate high rates of lifetime trauma (Anooshian, 2005; Gewirtz, 2010). By age 12, 83% have been exposed to at least one serious violent event (Bassuk et al., 1996; Bassuk et al., 1997; Buckner, Beardslee, & Bassuk, 2004).

The rates of trauma for children's parents across service sectors are also extraordinarily high. For example, in the public mental health sector, 51–98% of adult clients with severe mental illness have experienced childhood physical or sexual abuse (Cusack, Frueh, Heirs, Suffoletta-Maierie, & Bennett, 2003; Goodman et al., 1999; Mueser et al., 1998). In substance abuse settings, 75% of clients report histories of significant trauma (Jennings, 2004).

Exposure to interpersonal violence is considered a major cause of post-trauma responses for women (Report of the Federal Partners Committee on Women and Trauma, 2011). It is so widespread that many consider it a normative experience. In a nationally representative survey, nearly 1 in 5 women reported experiencing rape at some time in their lives, and more than 1 in 3 women have experienced rape, physical violence, or stalking by an intimate partner (CDC, 2012a; CDC, 2010). In mental health settings, over 50% of women report experiences of domestic violence (Friedman & Loue, 2007; Mowbray, Oyserman, Saunders, & Rueda-Riedle, 1998). In the criminal justice sector, 96% of female offenders have experienced trauma (Sarchiapone, Carli, Cuomo, Marchetti, & Roy, 2009), most often related to sexual abuse and domestic violence (Battle, Zlotnick, Najavits, Gutierrez, & Winsor, 2002; Zlotnick, Najavits, Rohsenow, & Johnson, 2003).

Low-income populations are disproportionately affected by trauma and served by social service systems of care. Unemployment and severe poverty, conditions that unduly affect African American and Latino populations, leave many low-income adults feeling frustrated, ashamed, and hopeless, and at increased risk for relationship violence (Catlett, Toews, & Wahilko, 2010; Daly, Power, & Gondolf, 2001; Heise & Garcia-Moreno, 2002; Kantor & Jasinski, 1998). For example, research indicates that over 90% of severely poor, homeless mothers have a lifetime history of trauma (Bassuk et al., 1996, 1997; Hayes, Zonneville, & Bassuk, 2013), 81% experienced multiple traumas, and more than half were victimized as children (Hayes, Zonneville, & Bassuk, 2013). Similarly, low-income minority men experience high rates of violence in their lives, few social supports, and high rates of PTSD (National Center for Injury Prevention and Control, 2003; Rich & Grey, 2005). The consequences of untreated trauma for mothers and fathers can be profound for the next generation.

Neurodevelopmental and Economic Impact of Trauma

A growing body of research has emerged on the impact of traumatic stress. Advancing knowledge of the neurobiology of trauma offers compelling evidence of its long-term impact on the brain and body, and the significant costs to society when trauma goes unaddressed.

An event becomes traumatic when it overwhelms the neurophysiological system for coping with stress and leaves people feeling unsafe, vulnerable, and out of control (Herman, 1992; Macy, Behar, Paulson, Delman, & Schmid, 2004). In the face of a confirmed threat, the amygdala and hypothalamus, structures in the limbic system—the brain's emotional control center—activate the body's survival responses: fight (actively confronting the source of the stress), flight (avoiding the stress), or freeze (shutting down) (Cohen et al., 2002; Perry, 2001; Saxe et al., 2006). Neurohormones, including adrenaline and cortisol, prepare the body for action to combat the threat and protect itself, and later, support a return to a physiological state of balance once the threat has passed (Perry & Pollard, 1998; Perry et al., 1996). Real and perceived threats continually retrigger the stress response, causing a person's neurological system to go into a state of disequilibrium. In this constantly dysregulated state, an array of maladaptive behavioral responses can develop.

For children, exposure to early and ongoing traumatic stress (e.g., child abuse, neglect, family violence) without adequate parental and other supports can lead to a "toxic stress" response that has profound effects on brain development (Center for the Developing Child at Harvard University, 2010; Cook et al., 2005). The neurobiological impact of prolonged heightened stress responses and elevated stress hormones includes changes to brain architecture and to the functioning of neural pathways including those associated with learning, memory, and the ability to self-regulate and cope. Also, it results in a heightened baseline state of physiological arousal and increased sensitivity to internal and external triggers (Cohen et al., 2002; National Scientific Council on the Developing Child, 2005; Perry, 2001; Perry et al., 1996; Putnam, 2006; Saxe et al., 2006). These alterations place children at greater risk for adverse developmental, emotional, functional, and academic outcomes (Berliner, 2006; Cook et al., 2005; Fairbank & Fairbank, 2009; Hopson & Lee, 2011; van der Kolk et al., 2005).

Trauma that goes unrecognized and unaddressed in childhood has long-term individual and societal implications. The groundbreaking Adverse Childhood Experiences (ACE) Study highlights the significant connection between childhood exposure to trauma and adverse adult outcomes. Specifically, multiple ACE (e.g., physical or sexual abuse, witnessing violence) are associated with social, emotional, and cognitive impairment; high-risk behaviors as coping mechanisms (e.g., eating disorders, smoking, substance use, self-harm); severe health problems; and greater risk of early death (Felitti & Anda, 2010; Felitti et al., 1998).

The cost of not addressing trauma in both human and economic terms is significant. PTSD, often a chronic condition lasting for many years, is comparable to that of other serious mental disorders (Kessler, 2000). For example, for female victims of domestic violence, 50% suffer from clinical depression and 24% meet criteria for PTSD (Goodwin, Chandler, & Meisel, 2003). Children who witness domestic violence also suffer from high rates of PTSD, depression, and anxiety and are at greater risk for becoming perpetrators of violence as adults (Ehrensaft et al., 2003; Kitzmann, Gaylord, Holt, & Kenny, 2003; Renner & Slack, 2006; Wolfe et al., 2003).

It is estimated that for domestic violence alone, the total cost across health, justice, and child serving systems is $37 billion annually (National Center for Injury Prevention and Control, 2007). In addition, the lifetime cost for child maltreatment per victim is approximately $210,000 in 2010 dollars (Fang, Brown, Florence, & Mercy, 2012). Just one year of confirmed cases of child maltreatment is estimated to cost approximately $124 billion (Fang et al., 2012; CDC, 2012b). Costs impact healthcare, employment, child welfare, criminal justice, and education. Taken together, the extraordinary toll that traumatic stress and interpersonal violence can take on individuals and society necessitates that we address trauma, and its impact, across all systems of care.

An Ecological View of Trauma and Intervention

Awareness of trauma and advances in the science of traumatic stress have helped practitioners in the field to understand, diagnose, and address posttrauma responses. PTSD is now a well-established diagnostic category (American Psychiatric Association, 2013); as a diagnosis, it is unique in its focus on context in the cause and relief of symptom expression (United States Department of Veterans Affairs, 2014).

Within the field, there is growing interest in understanding more about the complex manifestations of PTSD and its relationship to individual and external factors, (e.g., age of onset, number and type of traumatic experiences, social supports, and family and cultural context) (Cook et al., 2005). In particular, much attention has recently been paid to understanding the dynamic relationship between risk and protective factors. Research on trauma and resiliency highlights the importance of factors beyond individual traits in the human response to traumatic experiences (Bonanno et al., 1995, 2002, 2004; Bonanno, 2014; Cutuli & Herbers, 2014; Harvey, 2007; Masten et al., 1999, 2011; Masten & Coatsworth, 1995, 1998; Masten, Herbers, Cutuli, & Lafavor, 2008; Pat-Horenczyk, Rabinowitz, Rice, & Tucker-Levin, 2009). This represents a move away from a strictly medical model of individual illness towards a broader understanding of how environmental factors impact functioning and recovery (Bloom, 1997; Harvey, 2007; SAMHSA, 2014).

Trauma-informed care represents an ecological approach to trauma intervention based on the understanding that (a) environmental factors influence well-

being; (b) health is, at least in part, socially-determined; and (c) interventions must target individual, interpersonal, and community systems (Bronfenbrenner & Morris, 1998; SAMHSA, 2014; Saxe et al., 2006). This approach reflects a heightened awareness of context and the role that providers play in hindering or fostering recovery for trauma survivors (Harris & Fallot, 2001; Jennings, 2008). From an ecological perspective, organizations and systems are seen as critical targets of trauma intervention. As such, the focus of interventions expands beyond the individual therapy hour into the larger environment. As the paradigm shifts from asking survivors "what's wrong with you," to "what happened to you" (Harris & Fallot, 2001; SAMHSA, 2014), trauma-informed care broadens the approach to intervention from "how can I fix you" to "what do you need to support your development and recovery?"

Trauma-Informed Care: Current Models and Practice

As an outgrowth of the study of traumatic stress, trauma-informed care is relatively new. The U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) spearheaded this movement and led the call for trauma-informed care. The seminal Women Co-Occurring Disorders and Violence Study, a five-year multisite study that began in 1998, was the first federal effort to address the service needs of women with co-occurring substance use and mental health disorders who experienced trauma and helped set the federal direction around trauma-informed care (Moses, Reed, Mazelis, & D'Ambrosio, 2003). SAMHSA continues to be a leader in the field in defining and integrating trauma-informed care with efforts including supporting the National Child Traumatic Stress Network (NCTSN) to develop and pilot interventions to address the mental health impact of traumatic stress on children; launching its National Center for Trauma-Informed Care (NCTIC) to provide training and consultation to support service systems, particularly behavioral health, to address trauma; and most recently, developing a comprehensive treatment improvement protocol (TIP) to set the standard for trauma-informed care in behavioral health (SAMHSA, 2014).

In addition to federal leadership, many others played an early role in shaping the field of trauma-informed care. The National Association of State Mental Health Program Directors (NASHMPD), who passed a resolution in 1999 to recognize the pervasive impact of violence and trauma, called for trauma-specific services in mental health agencies, and developed criteria for building a trauma-informed mental health system (Power, 2011). In 2001, Maxine Harris and Roger Fallot published *Using Trauma Theory to Design Service Systems,* and articulated an early vision of trauma-informed care in social service systems. In addition, Sandra Bloom's Sanctuary model brought trauma-informed care to the therapeutic milieu within residential treatment and beyond (Bloom, 1997).

Current Models and Tools for Implementing Trauma-Informed Care

A range of established models and tools have been developed to help organizations become trauma-informed. In *Using Trauma Theory to Design Service Systems,* Harris and Fallot (2001) articulate a comprehensive array of strategies that organizations can take to adopt trauma-informed care. To accompany this book, Community Connections developed Creating Cultures of Trauma-Informed Care (CCIT), a model that includes (a) a trauma-informed services self-assessment and planning protocol; (b) a trauma-informed self-assessment checklist; and (c) a trauma-informed services implementation form (Fallot & Harris, 2011). Sandra Bloom's Sanctuary model offers organizations concrete tools for operationalizing the model's core principles within milieu settings (Bloom, 1997). The Sanctuary Institute offers intensive training and consultation over several years to fully adopt the model.

In addition to these models, there are a number of organizational self-assessments to guide agencies through the change process including Maine's System of Care Trauma-Informed Agency Assessment for child serving agencies (Yoe, Hornby, Goan, & Tiernan, 2012); The National Council for Behavioral Health's Organizational Self-Assessment (National Council for Behavioral Health, unpublished); the Chadwick Center's Trauma System Readiness Tool for child welfare agencies (Chadwick Center for Children & Families, 2013); and The National Center on Family Homelessness's Trauma-Informed Organizational Self-Assessment, adapted for homeless service settings, such as agencies that serve women veterans and community-based organizations that serve displaced children and families (Clervil, Guarino, DeCandia, & Beach, 2013; Guarino et al., 2009; Guarino, 2011). Assessment tools include concrete benchmarks of trauma-informed care for daily practice. Though not formal measures of the extent to which an organization is trauma-informed, these tools provide a valuable roadmap and process for organization-wide, trauma-informed change.

Key Components of Trauma-Informed Care

Providing trauma-informed care requires an organizational commitment to building employees' awareness, knowledge, and skills to support recovery. At minimum, trauma-informed organizations endeavor to do no further harm and avoid retraumatizing clients (Moses, Reed, Mazelis, & D'Ambrosio, 2003). Core principles of trauma-informed care across models include trauma knowledge, safety, choice, empowerment, and cultural competence (Hopper et al., 2010). Regardless of the services an agency provides, organizations can adopt these trauma-informed principles to assist those they serve in reaching goals and achieving success.

Providing trauma-informed care requires an organization-wide commitment to translating principles into concrete practices across all areas of programming. Although variability exists across current models, organizational domains identified as areas to target for developing trauma-informed practices include (a) sup-

porting staff development; (b) creating a safe and supportive environment; (c) assessing and planning services; (d) involving consumers; and (e) adapting policies (Guarino et al., 2009).

Implementation: Challenges of Shifting Models

In traditional service systems, the impact of trauma is not well understood by providers, and traumatic experiences are generally not seen as related to problems or symptoms. Service providers are viewed as experts, and compliance by the client is expected. Force and coercion may sometimes occur to ensure compliance (Prescott, Soares, Konnath, & Bassuk, 2008; Jennings, 2008; Bloom, 2000). Traditional systems may also cause additional harm by engaging in retraumatizing practices that mimic past trauma (e.g., rigid rules, lack of confidentiality, and harsh and punitive discipline practices) (Jennings, 2004, 2008). These experiences often leave trauma survivors feeling abused by the system and reluctant to trust service providers (Bloom, 2000; Elliott et al., 2005; Harris & Fallot, 2001; Jennings, 2008).

Without an awareness of trauma and its impact, service providers run the risk of misunderstanding, misdiagnosing, and mistreating children and youth. Traumatized children and youth may seem emotionally out of control, avoid taking responsibility, and appear disruptive or withdrawn (Hodas, 2006). Providers may label these children as "oppositional" or "spacey" (Guarino & Bassuk, 2010), or misdiagnose them as having ADHD, bipolar, or oppositional-defiant disorders (Cook et al., 2005; D'Andrea et al., 2012). Viewed on the basis of presenting symptoms alone, providers are likely to overlook the underlying traumatic experiences that may be the source of dysfunction (Cook et al., 2005; D'Andrea et al., 2012).

With training in trauma-informed care, providers and organizations can shift their perspectives and practices from the traditional to trauma-informed. For example, children's responses once viewed as disruptive are now understood as survival skills developed in response to earlier traumatic experiences. Changes in policies and practices may include (a) providing regular staff training on trauma and its impact; (b) reducing potentially triggering or retraumatizing practices such as restraint; (c) creating physical and emotional safety in relationships and in the environment; (d) using questions about trauma in all assessment protocol; and (e) giving survivors a voice and choice in all aspects of treatment (Guarino et al., 2009; Hopper et. al., 2010; SAMHSA, 2014). Finally, a trauma-informed approach takes into account the impact that working with trauma survivors has on providers (e.g., secondary traumatic stress) and includes practices to create a culture that supports provider self-care.

Implementing trauma-informed care is not without its challenges. The service delivery context, organizational values, and characteristics of providers and clients can affect training effectiveness and service delivery. In many health and human service organizations, delivery of quality services is often hampered by high staff turnover, resistance to change, limited resources, inadequate training opportuni-

ties, limited career ladders, and uninformed provider work attitudes (Atkins et al., 1998; Glisson et al., 2008a, 2008b; Lorenzi & Riley, 2000; McKay et al., 2006; Sexton & Kelley, 2010). Limited time for staff to attend trainings and limited supervisory and clinical capacity can present real barriers to delivering trauma-informed care. Additionally, many providers in community agencies view the initiation of trauma-informed care as akin to opening Pandora's Box. They fear creating needs that cannot be met (Moses et al., 2003), and many express fear of having to deal with difficult topics like sexual abuse. Resistance to creating trauma-informed services, however, often stems from a lack of knowledge about the impact of trauma, uncertainty of appropriate service responses, and for some providers, unresolved personal traumas.

Despite these challenges, trauma-informed care represents a relatively low-cost and high-yield investment to address the high rates of trauma for children, youth, and families. The primary investment in staff training and workforce development ensures all those working with children and families have knowledge of trauma. Systems change demands commitments by leadership to set clear expectations of how organizations will and will not operate and to ensure staff have the resources they need to do the job. Current research suggests that the potential benefits to children, youth, and families far outweigh the cost of system change.

Evaluation and Outcomes of Trauma-Informed Care

Evaluation and Measurement

Currently, there is not one standard of measurement to assess to what degree an organization is trauma-informed and if an organization providing comprehensive trauma-informed care produces better outcomes for the children and families served. As an organizational framework, trauma-informed care encompasses everything from the physical environment to the quality of client interactions with staff. Without a standard of measurement, it is difficult to definitively link the degree of "trauma-informedness" of an organization (e.g., high or low trauma-informed) to indicators of well-being for children and families, (e.g. PTSD symptom reduction, a decrease in child welfare or justice involvement, and an increase in residential stability).

Over the years, research utilizing various organizational climate scales has been done to identify factors within the environment that affect staff attitudes and behaviors, as well as treatment outcomes (Friedman, Clickman, & Kovach, 1986; Holahan & Moos, 1982; Moos & Moos, 1983; Lemke & Moos, 1987). One of the most well-known social climate scales is the Community Oriented Programs Environment Scale (COPES) (Moos, 1974). Developed by Rudolph Moos to evaluate the social environment of residential treatment facilities for emotionally disturbed children, this standardized social climate scale assesses a program's internal functioning and allows for comparison across programs. The Survey of Organizational

Functioning (SOF) measures organizational climate and culture, motivation for change, and staff attributes (Lehman, Greener, & Simpson, 2002). The Center for Disease Control's (CDC's) questionnaire, the KABB, measures the effectiveness of a training program on intimate partner violence (IPV) by focusing on health professional staff's knowledge, attitude, beliefs, and behaviors (Gadomski et al., 2001; Soliman, 2001).

Although organizational climate scales can be used to assess an organization's culture, to date none of these have been adapted or tested to specifically measure the degree and effectiveness of trauma-informed care. Process tools that help organizations become trauma-informed provide benchmarks for organizational change, but these tools are not validated, standardized instruments with psychometric properties. A review of literature suggests that no standardized instruments of trauma-informed care currently exist.

Outcomes

In 2010, Hopper, Bassuk, and Olivet conducted a comprehensive review of the field to assess the level of trauma-informed care as an emerging, promising practice. Their review included a synthesis of published quantitative and qualitative studies, community-based program evaluations, and unpublished pilot studies. They also made contact with programs that were utilizing trauma-informed care models, and gaps in the field were identified. A variety of promising outcomes were found.

The most studied model to date is Sanctuary (Bloom, 1997). A series of studies have been conducted to assess the extent to which programs using Sanctuary were operating as therapeutic communities, as compared to traditional residential treatment units (Rivard et al., 2003; Rivard et al., 2004; Rivard, Bloom, McCorckle, & Abramovits, 2005). Assessed using various combinations of organizational scales, such as COPES, youth measures (for example, Rosenberg Self-esteem Scale and the Child Behavior Checklist), and focus groups, positive changes in residential treatment environments serving youth have been noted (e.g., greater empathy by staff and greater sense of safety in environment). Focus groups indicated a growing awareness and understanding among staff of trauma and its impact, however only minor effects were noted on individual client behaviors.

Overall, preliminary outcomes associated with trauma-informed care include decreased emotional reactions for program participants, decreased crises in programs, enhanced sense of safety, and greater collaboration among service providers (Community Connections, 2002; Cocozza et al., 2005; Morrissey, Ellis, & Gatz, 2005; Noether et al., 2007). A few pilot programs have demonstrated some improvement in client functioning in trauma-informed service settings (Morrissey, Jackson, & Ellis, 2005; Kramer, unpublished), suggesting that trauma-informed care is a cost-effective approach to addressing trauma as compared to standard or traditional programming (Domino, Morrissey, Chung, Hunington, Larson, & Russell, 2005).

Implications and Next Steps for the Field

The study of traumatic stress evolved alongside significant cultural and political shifts that brought trauma into society's consciousness. This context supported the rights of the victimized, prioritized the need for healing relationships and recovery-oriented environments, and politically gave "voice to the disempowered" (Herman, 1992, p. 9). The concept of trauma-informed care emerged from this ever-evolving recognition and understanding of trauma and the role of the broader environment in addressing this public health issue.

Despite the recent calls for trauma-informed care across service sectors, the current discourse indicates a lack of clarity. Providers, policymakers, funders, and researchers vary widely in their understandings of the concept and use of the term, and may disagree about the relative efficacy of trauma-specific services versus trauma-informed care. Trauma-specific services refers to clinical interventions that treat symptoms of PTSD. Trauma-informed care refers to practices and policies that can be implemented by entire organizations, not just clinical staff, and involves modifications to organizational culture and practice (Guarino et al., 2009; Harris & Fallot, 2001; SAMHSA, 2014). Despite the distinction, sometimes the terms are used interchangeably, which confounds the evidence base.

Currently, the field has an array of process tools that assist organizations in becoming trauma-informed, but data are lacking about the effectiveness of trauma-informed environments (Hopper et al., 2010). To move forward, the evolution of trauma-informed care will require (a) a clear consensus on the definition, principles, and components of trauma-informed care to create a uniform set of practice guidelines; (b) instrumentation to measure its effectiveness and assess organizations to capture their degree of trauma-informed care and its link to client-level indices of well-being; (c) methodologically rigorous studies to build the evidence base of trauma-informed care as a framework and complement to trauma-specific services, and; (d) public and private support, at the federal, state and local levels, to fund research and implementation.

Taking these next steps will require a shift in priorities and a commitment by leaders at all levels to invest in developing the human service workforce. In this time of shifting paradigms, we have a choice. If we simply react to its current popularity only to lapse back into more comfortable and familiar patterns, we run the risk of trauma-informed care being nothing more than a passing fad. However, if we respond by acknowledging the extent of trauma in the lives of children and families, we can transform our systems to be more responsive to all. Compared to the human and economic toll of unaddressed trauma, trauma-informed care implemented across service systems represents a relatively low-cost approach to address human suffering.

Conclusion

Given the widespread prevalence of violence and trauma in the lives of children and families, there is a consensus that all service systems become "trauma-informed" (Report of the Federal Partners Committee on Women and Trauma, 2011; SAMHSA, 2014). However, there remains a lack of clarity about the concept and inconsistency in its implementation (Hopper et al., 2010). Shifting from the dominant paradigm is no small feat. Professionals are often reluctant to let go of accepted models or theories that are familiar, and systems are strongly resistant to change (Lorenzi & Riley, 2000). Are we ready to shift our public service systems and respond to trauma in coordinated, evidence-based ways? Are we ready to invest in the human service workforce, many of whom are paraprofessionals, to make trauma-informed care a standard of care? If we don't make this investment, it is likely that the current wave of interest will crest and eventually succumb to the forces of history as we once again deny the extent of trauma in the lives of children and families. When we look into the eyes of a child who has experienced trauma, the real question we must ask ourselves is: how can we not?

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YOUTH THRIVE: A FRAMEWORK TO HELP ADOLESCENTS OVERCOME TRAUMA AND THRIVE

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Youth Thrive Origins and Framework

Helping youth realize their dreams while also keeping them safe and attending to their physical and emotional needs is the goal for all parents. Balancing dreams and needs also defines the role of those working with youth in the child welfare system. In 2011, the Center for the Study of Social Policy (CSSP) began an effort to reverse the troubling outcomes that many young people in the foster care system experience (Courtney, 2009) and to capitalize on the inherent strengths that exist in these youth. CSSP is a national nonprofit organization dedicated to improving life chances for our country's most vulnerable children, youth, and families and has a long history of working with child welfare systems to produce better results. CSSP's interest in creating a youth development agenda coincided with several other important changes: breakthroughs in the field of adolescent brain development, the passage of the federal Fostering Connections to Success and Increasing Adoptions Act[1] in 2008, and the federal call for child welfare agencies to elevate their focus on child and youth well-being, in addition to safety and permanency.

Recently there has also been a growing belief in communities and among child welfare and youth services experts as to the value of practitioners dealing with both risk factors that compromise a child's life prospects (e.g., family violence) and protective and promotive factors (e.g., resilience, social connections) that minimize risk and advance well-being (Epstein, 2004). By drawing attention to the importance of balancing attention to risk reduction with that of the promotion of health, the Youth Thrive Framework is consistent with the tenets

1 This federal law promotes permanent families for children and youth in foster care through relative guardianship and adoption, as well as improving education and health care services, extending federal support for youth to age 21, increasing opportunities for success when youth leave care, and providing federal protections and support to American Indian children.

of positive youth development that recognizes that "problem-free does not mean fully prepared" (Pittman, 1992, p. 1). This article describes CSSP's Youth Thrive protective and promotive factors framework and examines how a focus on thriving is necessary to complement the growing interest in being trauma-informed.

This article describes CSSP's Youth Thrive protective and promotive factors framework and examines how a focus on thriving is necessary to complement the field's growing move to become trauma-informed. Previous efforts to identify protective factors targeted the developmental needs of the youngest children, up to six years old, aiming to help parents to promote the healthy development of their children (Horton, 2003). Youth Thrive posits a research-informed framework for building protective and promotive factors for adolescents and young adults, ages 9–26 years old, particularly the most vulnerable youth (Harper Browne, 2014).

The Youth Thrive framework is based on what the research on resilience, positive youth development, neuroscience, and trauma indicates contributes to healthy development and well-being and reduces the impact of traumatic and negative life experiences for all youth. The research led to the identification of five protective and promotive factors that mitigate risk and promote well-being, as well as the concomitant critical outcomes that constitute healthy adolescent development. The Youth Thrive protective and promotive factors[2] are:

- ***Youth Resilience:*** Managing stress and functioning well when faced with stressors, challenges, or adversity; building on individual characteristics, strengths, and interests.
- ***Social Connections:*** Having healthy, sustained relationships with people, institutions, the community, and a force greater than oneself that promote a sense of trust, belonging, and that one matters.
- ***Knowledge of Adolescent Development:*** Understanding the unique aspects of adolescent development including information on adolescent brain development and the impact of trauma; implementing developmentally and contextually appropriate best practices.
- ***Concrete Support in Times of Need:*** Understanding the importance of asking for help and advocating for oneself; receiving quality services (e.g., health care, housing, education) designed to preserve youths' dignity, provide opportunities for skill development, and promote healthy development.
- ***Cognitive and Social-Emotional Competence:*** Acquiring skills and attitudes (e.g., executive functioning, character strength, future orienta-

2 For more information on the Youth Thrive protective and promotive factors go to http://www.cssp.org/reform/child-welfare/youth-thrive

> tion, persistence, and positive emotions) that are essential for forming an independent identity and having a productive, responsible, and satisfying adulthood (Harper Browne, 2014, p. 3).

The Youth Thrive Framework provides a roadmap for workers, foster parents, managers, and administrators to operationalize the somewhat amorphous concept of "well-being" for youth in foster care or who have experienced abuse, neglect, or other adverse experiences. By being deliberate and intentional about building these protective and promotive factors in their everyday encounters with the youth they support, youth workers can increase the likelihood of making significant, positive differences in the lives of youth resulting in improved outcomes.

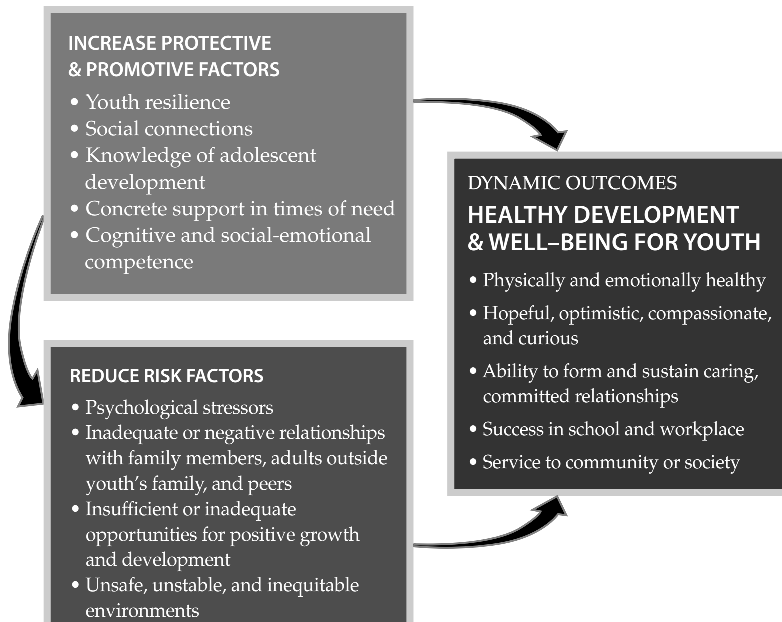

Figure 1: Youth Thrive Framework (Center for the Study of Social Policy, 2013)

Trauma and Adolescence

During adolescence the brain experiences a great wave of growth and development, second only to the rapid development that occurs during the first years of life (Siegel, 2013). Despite the acknowledged impact of trauma on brain development, this new research also suggests that positive experiences and opportunities can help create new neural pathways, build new brain architecture, and help youth heal from trauma and grow into mature, successful adults (Shonkoff & Garner, 2012).

All youth have stressful experiences from time to time. In fact, exposure to experiences that create mild or positive stress is considered necessary for healthy development because youth have "the opportunity to learn how to effectively manage stress, regulate emotions, and develop the social, behavioral, and cognitive coping resources needed to overcome these obstacles" (Gunnar, Herrera, & Hostinar, 2009, p. 4). Youth need to learn to cope with stressful situations, such as experiencing failure, in order to be fully prepared for adulthood (Harper Browne, 2014).

However, some youth are faced with extremely intense stressful experiences—traumatic events—such as being in a serious car accident, being abused by a caretaker, or witnessing violence in their neighborhood. It is estimated that 26% of American children will witness or experience a traumatic event before the age of four (Briggs-Gowan, Ford, Fraleigh, McCarthy, & Carter, 2010). The National Child Traumatic Stress Network (NCTSN) states, "Children who suffer from child traumatic stress are those children who have been exposed to one or more traumas over the course of their lives and develop reactions that persist and affect their daily lives after the traumatic events have ended" (2003, p. 1).

According to the NCTSN (n.d.), traumatic events can be differentiated by the duration of the event and classified as "acute" or "chronic" trauma. Acute traumatic experiences (e.g., school shootings, death of a loved one) "occur at a particular time and place and are usually short-lived" (NCTSN, n.d., para. 1). Chronic traumatic experiences (e.g., recurring sexual or physical abuse, persistent neglect, family violence) "occur repeatedly over long periods of time" (NCTSN, n.d., para. 3). Both types of traumatic experiences can cause immediate and enduring negative biological, psychological, and behavioral effects; the effects of trauma on early brain development, in particular, can be significant.

When faced with any type of stressful event, the brain automatically triggers the body's stress response system, which is a series of physical changes such as increased heart rate, blood pressure, and production of stress hormones. Traumatic experiences create an intense and sustained activation of the body's stress response system, referred to as "toxic stress" (Middlebrooks & Audage, 2008; Shonkoff & Garner, 2012). "Extensive research on the biology of stress now shows that healthy development can be derailed by excessive or prolonged activation of stress response systems in the body and the brain, with damaging effects on learning, behavior, and health across the lifespan" (National Scientific Council on the Developing Child, 2005/2014, p. 1). Several damaging effects of toxic stress on early brain development that, without intervention, can become most evident during adolescence have been identified by researchers (see, e.g., Jim Casey Youth Opportunities Initiative, 2011; Langford & Badeau, 2013; Lupien, McEwen, Gunnar, & Heim, 2009; National Scientific Council on the Developing Child, 2005/2014). They include:

- Development of a smaller brain
- Low threshold for stress that results in being overly reactive to upsetting, challenging, or adverse experiences
- Difficulty managing stressful situations
- Difficulty regulating emotions and being emotionally attuned to others
- Heightened fear, anxiety, and impulsive responses
- Difficulty relating to other people and forming healthy relationships
- Cognitive deficits such as impaired reasoning, planning, and behavior control
- Suppressed immune system causing vulnerability to chronic health problems
  (Harper, 2014)

Pynoos and colleagues (2007) assert that one critical outcome of traumatic experiences is the formation of trauma-related expectations:

> By their very nature and degree of personal impact, traumatic experiences can skew [youths'] expectations about the world . . . These expectations . . . shape concepts of self and others and lead to forecasts about the future that can have a profound influence on current and future behavior (Pynoos et al., p. 332).

The effects of traumatic experiences are further exacerbated when youth have complex trauma histories. Complex trauma refers to "the dual problem of exposure to multiple traumatic events and the impact of this exposure on immediate and long-term development" (Jim Casey Youth Opportunities Initiative, 2011, p. 13). For example, many youth in out-of-home-care endure the trauma that led to the removal from their home, the trauma of being separated from their families, and the additional trauma of multiple removals and placements (Bruskas, 2008; Frerer, Sosenko, & Henke, 2013; Hieger, 2012). "Children exposed to complex trauma often experience lifelong problems that place them at risk for additional trauma exposure and cumulative impairment (e.g., psychiatric and addictive disorders; chronic medical illness; legal, vocational, and family problems)" (Cook et al., 2005, p. 390).

Although research has shown that exposure to traumatic experiences can interfere with healthy development and well-being, this does not mean negative outcomes are inevitable, even when children and youth experience complex trauma (Cook et al., 2005; Easterbrooks, Ginsberg, & Lerner, 2013; Jim Casey Youth Opportunities Initiative, 2011; Middlebrooks & Audage, 2008; Runyan et al., 2014).

Research has also shown, "even when stress is toxic, supportive parenting, positive peer relationships, and the availability and use of community resources can foster positive adaptation" (Easterbrooks et al., 2013, p. 102). That is, youth can learn to demonstrate resilience and to thrive when supported by trusted, nurturing, competent, and caring adults who offer positive guidance; provide opportunities for productive decision-making and constructive engagement in various social contexts; and promote the development of self-regulation, self-reflection, self-confidence, self-compassion, and character (Harper Browne, 2014; Jim Casey Youth Opportunities Initiative, 2011).

Bundick and colleagues (2010) delineated five core principles of thriving, based on a review of theoretical and empirical literature about this construct:

1. Thriving is an essentially developmental construct, which entails a general orientation toward and, over time, the realization of relatively stable movement along an upward (though perhaps nonlinear) life trajectory.

2. Thriving focuses on aspects of development beyond merely the absence of the negative, and beyond mere competence or simple achievement of developmental tasks—in this way, we might think of thriving as a theory of optimal development (not just adequate development).

3. Thriving refers to the functioning of the integrated, whole person across all life domains; thus, the term implies personal balance, such that one is not considered to be thriving if he or she is functioning and developing positively in one aspect or area of his or her life.

4. Thriving recognizes the multidirectional nature of relations between person and context, through which both the individual and his or her contexts are mutually enhanced. This notion of mutual enhancement implies a moral component of thriving—when thriving, individuals act on (and thus help create) their environments, they seek to in some way contribute to others and/or the multiple ecologies in which they are embedded.

5. Thriving entails the engagement of one's unique talents, interests, and/or aspirations. In this lies the assumption of one's self-awareness of his or her uniqueness, and the opportunities to purposefully manifest them. Through such engagement, one might be thought of as actively working toward fulfilling his or her full potential (pp. 891–892).

Youth Work to Address Trauma and Promote Thriving

At its founding and to this day, child and youth care work has maintained two central themes: (a) a focus on understanding and changing behavior and (b) using the activities of everyday life to model social skills and competencies (Stuart, 2012). Child and youth care work has increasingly focused on delivering

activities that build core competencies that are at the heart of the Youth Thrive framework. Youth workers seek to understand the meaning behind risk and organize daily life events as a milieu to demonstrate and teach youth to avoid unhealthy risks and cultivate protective factors that contribute to healthy behavior (Garfat, Fulcher, & Digney, 2013).

Given their frequent contact and often close relationships with young people, youth workers are in an opportune position to promote positive change over time. Youth workers take responsibility for what is commonly called "the other 23 hours"—that is all of the time outside the dedicated therapy hour during which social and emotional growth occurs (Brendtro, Whittaker, & Trieschman, 1969). During these hours, youth workers encounter the majority of the effects associated with youth who have experienced trauma. Trauma-informed approaches enable youth workers to utilize brain-based, neuroscience research to effectively address the neural changes associated with repeated exposures to trauma.

In order to effectively teach youth how to reprogram responses that have been shaped by past trauma, youth workers must be knowledgeable about brain development during adolescence and the effects of trauma on relationships and other aspects of a youth's life. For example, youth workers need to know that the adolescent brain develops unevenly; that is, different parts mature at different rates. The structures and functions in the limbic system that contribute to emotions—such as fear, anger, and pleasure—develop in early adolescence, but structures and functions in the prefrontal cortex—the area of the brain responsible for effective decision making, controlling impulses, and balancing risks and rewards—are still evolving well into early adulthood (Jim Casey Youth Opportunities Initiative, 2011). This imbalance can explain much of the perplexing, inconsistent, and at times problematic behavior typical to most adolescents. It is also important to be aware that the brain continues to strengthen the neural pathways that are used most frequently (Siegel, 2013). It is absolutely critical to recognize that since young adults' brains and their cognitive functions are still developing, all older youth deserve access to opportunities for positive youth development and a second chance (and sometimes additional chances) if necessary. In fact, these scientific insights should become a mandate for practice and policy (Samuels & Blitz, 2014).

Through repeated healthy experiences and activities organized by the youth worker, the brain can develop healthier patterns and behaviors based on positive interactions. Daily life events also provide repeated opportunities for youth to negotiate the practical challenges of relationships and effectively incorporate what they learn from the adults providing direct care. By being intentional about what the research says youth need in order to thrive and using trauma-informed approaches over time, workers can help youth build the protective and promotive factors that are associated with the dynamic outcomes of healthy development and well-being.

Mealtimes, sports, school, afterschool, and community service are all contexts in which youth workers can reduce risk and increase protective and promotive

factors by teaching youth healthy, appropriate behaviors for lifelong success in the community, at home, and eventually at work. In these venues and through these activities, youth workers can give youth opportunities to take reasonable risks and have new adventures, experiences, and challenges (e.g., through creative, artistic, academic or athletic pursuits; travel; acquisition of new skills) that adolescents seek but without the risk of potentially overwhelming negative consequences (e.g., from delinquency, high risk sexual behavior, drug abuse). Through these experiences, youth have the opportunity to develop a multitude of peer and adult relationships they can call upon and count on in difficult times. The network of peer relationships are equally important, as adults help youth foster friendships and engage in healthy, age-appropriate activities. In addition, youth can learn how to manage stress effectively, ask for help, and advocate for themselves—mastering core competencies associated with healthy development and well-being.

Implementation of the Youth Thrive Framework

While a conceptual framework that synthesizes new information is helpful, the promise of better outcomes for individuals and better performance for systems and services can only be realized if the framework is put into action. Towards that end, Youth Thrive provides a perspective or lens that can be used to examine and modify frontline practice, policy, organizational culture, and infrastructure. Over the past two years, CSSP has worked to further develop and implement the Youth Thrive Framework specifically with youth involved in the child welfare system.

CSSP is currently developing and piloting a variety of tools and materials that support the implementation of Youth Thrive strategies in policy and practice. For example, the National Resource Center for Youth Services (at the University of Oklahoma) and the Academy for Competent Youth Work have developed a Youth Thrive training curriculum. This training focuses on understanding the five protective and promotive factors and explores how outcomes can be improved by using Youth Thrive ideas to change direct practice. Units of the curriculum set the stage to fully explore the dynamics of the youth-adult partnership with the purpose of building strengths and reducing risk. Participants engage in interactive exercises to practice new skills that can be used in everyday interactions to reduce stress and promote practical problem solving.

Youth Thrive is also working with select jurisdictions. The State of New Jersey, under the leadership of the Department of Children and Families' Office of Adolescent Services has launched a comprehensive Youth Thrive initiative. The Commissioner established a new task force with the charge to review and make changes at every level in the delivery of services to older youth based on the Youth Thrive framework. Called the Task Force on Helping Youth Thrive in Placement (HYTIP), this cross-functional team is working to successfully change contracting and licensing language to reflect the critical implementation of protective and promotive factors. HYTIP is also working to better articulate the role of resource

and treatment homes in placing youth on the pathway to lifelong resilience. This translates into practical and critical efforts such as listening and acting on the recommendations of Youth Boards; preparing Youth Thrive guides for youth, parents, and staff; and shifting the process of preparing for transitioning out of care to better reflect normal adolescent healthy growth and development (Task Force on Helping Youth Thrive in Placement, n.d.).

Youth Thrive is also working with the Brevard Family Partnership, a community-based organization that delivers child welfare services in Brevard County, Florida. The Brevard Family Partnership's adoption of the Youth Thrive Framework complements the State's agenda to create "normalcy" in the lives and experiences of all youth in Florida's foster care system. While the New Jersey experience represents the power of what a government jurisdiction can do to better guide every service, policy, and practice to result in resilience for youth, Brevard County represents the potential of a community-driven approach for helping youth in care to thrive.

The Partnership has brought together a roundtable of representatives from the different sectors serving adolescents. In Brevard, a trauma-informed care youth summit was launched in which more than 400 leaders across the community have twice gathered to respond to the youth's recommendations of what they need to succeed and thrive. This community café dialogue was led by successful young leaders who grew up in foster care. It resulted in action steps to be pursued through the system of care including service providers, churches, government leaders, educators, business executives, and other stakeholders. The Youth Thrive committee meets on a monthly basis to identify and implement ways in which policies and practices within the region can adopt the protective and promotive factors framework. The committee's goal is to engage the whole community in helping youth to manage risk and move towards resilience.

Youth Thrive Search for Exemplary Initiatives

During 2014, CSSP conducted a national search to identify and recognize initiatives that are robust exemplars of programs, policies, services and advocacy efforts that operationalize the Youth Thrive protective and promotive factors. The purpose of the search was multifaceted: to increase awareness and understanding of the Youth Thrive approach; to strengthen the case for this approach by providing tangible, on-the-ground examples; to learn about and share effective strategies; and to identify and build a national network of skilled practitioners and leaders committed to the healthy development and well-being of adolescents.

CSSP invited nominations for initiatives that work with youth involved in the child welfare system (i.e., foster care, prevention, or postplacement services) and that explicitly address the protective and promotive factors. Additional selection criteria for the exemplary initiatives included the following: be innovative and go beyond the basics to do something exceptional; employ a strengths-based

approach; develop and maintain systems and infrastructure that support the initiative (e.g., hiring, training, supervision, data collection and analysis, quality improvement); be attuned to the needs of diverse racial and ethnic groups and to LGBTQ[3] populations; and assess impact on youth and show evidence of effectiveness.

The search began with an open, online request for nominations that CSSP widely distributed to individuals and networks familiar with youth-serving programs. Nominated programs went through an extensive application and rigorous review process which included submitting detailed written information, a telephone interview, a site visit, and interviews with youth, families, and staff. The search was conducted by CSSP staff and consultants. An expert panel—with expertise in youth development, child welfare, public policy, research, and trauma-informed care—provided guidance on the search process. Youth advisors served on the panel, and young leaders with experience in the child welfare system participated as part of the review team on the site visits.

Out of an initial pool of more than 130 nominations, CSSP recognized 15 exemplary initiatives. These initiatives represent a variety of organizations—public and nonprofit, service providers and advocacy efforts, community-based providers, and large multi-state programs. They employ a wide variety of strategies and engage in diverse activities—all with a shared goal of improving outcomes for youth who have been involved in the child welfare system. The range of selected initiatives include: a statewide youth advisory board; programs implementing aggressive strategies to ensure youth have lasting, positive connections to family; universities providing scholarships and campus-based support for former foster youth; educational champions advocating for individual students and improvements in public education systems; training for staff working with pregnant and parenting teens; and a neighborhood center with employment, recreation, and supportive services for youth in foster care.

Trauma-Informed Practice and Attention to Thriving

All of the Youth Thrive exemplary initiatives are aware of the growing importance of recognizing and understanding trauma, and many have incorporated aspects of trauma-informed care into their work with youth. For several of the initiatives, addressing trauma is fundamental to their philosophy and a hallmark of their approach. Their specific strategies are powerful illustrations of how youth-serving organizations and youth workers can put a trauma-informed orientation into action. These initiatives combine attention to trauma with a vital commitment to promoting adolescents' well-being in order to help youth truly thrive.

Based in Milwaukee, SaintA is an organization that provides foster care, mental health, and education services. It is in the forefront of understanding the impact of trauma on the developing brain and changing policy and practice to reflect that

3 Lesbian, gay, bisexual, transgender, and questioning populations.

understanding. An essential first step in that shift is changing attitudes and reframing the conversation with youth from: "What is wrong with you?" to "What happened to you and how can I support you?" In collaboration with Dr. Bruce Perry, of the Child Trauma Academy, and Dr. Robert Anda, co-investigator on the Adverse Childhood Experiences Study (ACE), SaintA is integrating trauma-informed practice into all of its services.

SaintA uses Perry's Neurosequential Model of Therapeutics (Perry & Hambrick, 2008) and other tools to examine youth's history and current functioning. It utilizes these assessments to understand an individual's trauma experiences and the impact on their physical and emotional development. With this information, SaintA staff determine appropriate interventions to mitigate past trauma and re-evaluate interventions over time. In terms of treatment, SaintA customizes therapeutic responses for each youth's experience and often uses sensory-based interventions—such as yoga, drumming, singing, knitting, and physical activities such as dance or horseback riding—that address lower brain function. These types of rhythmic, repetitive activities help calm the brain and support self-regulation. This is an important distinction from other more traditional treatment interventions that typically focus on cognitive or executive tasks that constitute upper parts of brain function.

Cultivating calm, close relationships between family members, staff, and youth is central to SaintA's work to ensure that all understand the impact of past trauma and are ready to help youth heal and thrive. SaintA staff pay particular attention to ensuring a good fit with foster families and building caregiver capacity to establish safe environments and consistent relationships. It is an agency priority to keep youth within their communities and schools so that the trauma of being removed from their family is not further exacerbated by additional disruptions.

A powerful indication of SaintA's commitment to being trauma-informed throughout its operations is that all staff—not just direct service workers but also janitorial, kitchen, administrative, and managerial employees—attend training to understand trauma and its impact on youth and families. This training process transforms how employees view their work. For example, maintenance staff have a different insight into why a young person might damage property. SaintA has also incorporated trauma-informed commitments into all job descriptions and created a culture where interactions with the children, youth, and families are empathic and consistent with the overall mission of the organization. The agency's goal is to support youth to heal from the trauma they experienced and, as one youth served by SaintA, said, "Be in a situation where you can move forward with all the tools you need."

In addition to reforming all of its own internal operations, SaintA is conducting training and building networks to spread trauma-informed care throughout the state of Wisconsin including training for schools to become trauma-sensitive. Its goal is to educate other human service professionals and community members to understand the ingredients of trauma-informed care. They have reached over 10,000 practitioners to date.

Another powerful example of trauma-informed work is at Anu Family Services (Anu). In 2006, Anu set an ambitious goal: to be the last placement prior to permanence for 90% of the youth they serve. That year, 38% of youth leaving Anu's foster care services were discharged to a permanent placement. By the end of 2012, that percentage had almost doubled to 70% (according to Anu Family Services Performance Measures for 2012). Anu's work is based on two key beliefs: (a) youth's past trauma, grief, and loss must be addressed in order for youth to form lasting, meaningful relationships and (b) the search for people who youth have loved and lost should be extensive and exhaustive.

Guiding all of Anu's work is the conviction that youth are the boss of the process. Youth have the right to hire and fire their caseworker and determine the pace and content of the work such as who to reach out to and when. Anu is determined to help youth progress from writhing to surviving to thriving. In helping youth address and confront grief, loss, and trauma and navigate the complexities of establishing relationships with adults, Anu Family Services empowers youth to tackle their own personal struggles in a supportive environment. Anu has documented its approach in a comprehensive, clear guidebook that addresses trauma-effective practice strategies with many relevant tools and graphics (Jones, LaLiberte, & Meyer, 2013).

Difficult to capture in writing is the intensity and urgency that Anu brings to its work with youth. It is not satisfied with typical service or system responses to youth that too often pathologize their behavior, readily medicate them, and react to difficulties by moving youth to new and often more restrictive placement settings—severing relationships and retraumatizing them.

The trauma compounds, and the youth have no safe place to express their intensive grief and loss or to process their trauma. Still, we continue to blame the youth for their behaviors, which are the result of trauma which we have either inflicted and/or failed to heal. We know more than we have ever known before about the impact of trauma, but we still have entire public and private systems that do not fully understand and, therefore, do not practice, trauma-informed care. Once we know better, we must do better (Jones et.al., 2013, p. 2).

Working in Minnesota and Wisconsin, Anu's permanence specialists carry small caseloads (8 or less) and use a variety of exercises (e.g., timelines, connection maps, permanency pacts) to help youth identify, strengthen, and maintain supportive relationships with adults. It employs evidence-informed practices such as the 3-5-7 Model developed by Darla Henry (Henry, 2012) which is comprised of three tasks, five questions, and seven skills to help youth understand their past, grieve losses, and prepare for permanence. Beyond the goal of permanence, Anu has adopted a four part model of well-being that is comprised of:

- using trauma-informed parenting
- building networks of support and connection

- addressing grief, loss, and trauma
- engaging in interactive healing interventions (Anu Model of Wellbeing, 2014)

Anu coaches customize services to each individual family and teach caregivers methods and tools they can use with youth to promote attachment, self-esteem, and the development of positive behaviors. In partnership with the Center for Spirituality and Healing at the University of Minnesota, Anu employs techniques not traditionally used in child welfare, such as mindfulness-based stress reduction, yoga, and equine therapy. These activities give youth the opportunity to engage in activities—other than formal counseling or talk-based therapies—that can enhance their well-being.

Another avenue for addressing trauma is through the arts. In Jacksonville, Florida, Family Support Services of Northern Florida, Inc., a large, comprehensive child welfare agency, engages youth in creative and performing arts to deal with past trauma and express who they have been, who they are, and who they want to become. At its three week summer camp called Just Like Me, youth are given complete creative license to follow their interest and write, sing, dance, paint, or make videos that tell their own stories. Just Like Me was designed for youth who are involved in the foster care system to help them develop their artistic talents and gain skills such as trust, teamwork, problem solving, and decision-making. Local professional artists lead classes in drama, dance, singing, songwriting, rap, spoken word, creative writing, photography, and visual arts.

Just Like Me intentionally serves the highest risk youth (e.g., youth who have been kicked out of placements, have mental health or substance abuse problems, and are victims of human trafficking). It targets young people who are not likely to be selected or participate in other academic, sports, or enrichment activities. During the camp, mental health counselors are available to help youth handle any issues that surface during the creative process. Each young artist leaves with a product of their work and participates in a culminating performance for an enthusiastic audience of family, foster parents, staff, media, and community members.

Through creative expression, Just Like Me helps youth in foster care recognize and capitalize on their strengths, acknowledge their challenges, manage adversity, and heal from the effects of trauma. Through intensive team-building activities, the youth increase their self-esteem and improve their communication and conflict resolution skills. Participants gain new social networks—of mentors, artists, and peers—that help youth develop a sense of connectedness, greater self-confidence, and personal responsibility. Youth also gain information about future education and career opportunities that use artistic and creative talents. Many camp participants maintain relationships with artists, agency staff, and other participants and return to participate in activities throughout the year.

Operating in 12 California counties, Seneca Family of Agencies (Seneca) is

another strong example of how trauma-informed strategies and a focus on thriving and resiliency are embedded within an organization's culture, policies, and clinical practice. Unconditional Care, as both a philosophy and treatment model, is the foundation and core conceptualization of all Seneca services delivered to youth and families referred by the child welfare, behavioral health, juvenile justice, and special education systems. As a philosophy and approach, Unconditional Care is reflected in numerous practical ways, including being available to families at the times and places that are most convenient for them, 24 hours/seven days a week; utilizing evidence-based and evidence-informed intervention strategies to garner the best possible outcomes; ensuring that every child leaves our care with a viable and sustainable permanency plan and relentlessly pursuing engagement even when initial attempts fail or falter. Indicative of Seneca's philosophy is its commitment to never discharge a young person for exhibiting the behavior that brought them to Seneca in the first place (Sprinson & Berrick, 2010).

In order to expand and strengthen the protective and promotive factors for vulnerable youth and their families, Seneca's Unconditional Care treatment model integrates three approaches to assessment and intervention: relational, behavioral, and ecological. The relational approach, grounded in attachment theory, assumes that effective intervention requires defining each young person's internal working model(s) and identifying specific and intentional ways of responding that do not reinforce his/her maladaptive internal schema of relationship. The behavioral approach, based upon social learning theory, focuses on modifying the settings and antecedents associated with troubling behaviors, as well as teaching more adaptive replacement behaviors through positive behavioral intervention. Ecological assessment and intervention, drawn from ecological systems theory, seeks to leverage resources and strengths in the family system to meet the child and family's unmet needs (Sprinson & Berrick, 2010), and ensure the family has a sustainable and enduring network of supports and permanent connections at the time of transition.

Offering a somewhat different perspective on the issue of trauma is the My Life Project, based at Portland State University in Oregon. The My Life Project works with youth who are preparing to exit the child welfare system. While staff are trained in understanding the impact of trauma on brain development, staff at this program do not read a youth's case record nor ask or expect a youth to talk about past experiences. Thus, they do not necessarily identify or address youth's past trauma explicitly. Coaches focus on helping youth set their own goals and solving problems identified and defined by young people themselves. My Life interventions entail learning and practicing key strategies such as requesting help and taking action.

My Life's guiding principle is self-determination, helping young people learn how to direct their own lives. Their work is founded on the premise of "nothing about me without me." In keeping with that commitment, youth themselves determine if and when they want to share their histories. In most instances, youth do choose to share their stories with My Life staff. My Life staff report that youth

greatly appreciate that staff get to know them first without any preconceived notions or judgments based on their past. The My Life Project is currently conducting a randomized control trial of its intervention and already has evidence of successful outcomes for the self-determination approach. A prior randomized study with a sample of 69 youth was conducted on the TAKE CHARGE model, the intervention on which the My Life Project is based. Serving youth who were in both foster care and special education, the evaluation found moderate to large effects post-intervention and at one year follow-up for youth who participated in the TAKE CHARGE intervention, specifically positive differences in self-determination, quality of life, and utilization of community transition services. Youth in the intervention group also completed high school, were employed, and carried out independent living activities at notably higher rates than the comparison group (Powers et al., 2012).

Conclusion

The momentum within the children's and youth service community toward becoming trauma-informed is a welcomed step toward helping youth who have had adverse experiences heal. Even while recognizing how difficult this system transformation will be, attention must not stop at helping youth to survive their past and make sense of their history. Rather efforts aimed at healing need to be combined with work that help youth identify, uncover, and build on their strengths, and ultimately thrive. Doing so requires intentional attention toward building and maintaining the protective and promotive factors that research indicates are associated with healthy adolescent development and well-being.

To ensure that workers, managers, and leaders are committed to helping youth to heal and to thrive, consider the following:

Choosing the workforce. Quality work obviously starts with clarity about the kinds of staff agencies want working with youth. Workers can be taught skills but they cannot be taught values. At a very basic level, youth workers have to like adolescents, enjoy working with them, and believe in their potential. They need to embody a strengths-based approach and be in the business of building hope. Staff who understand that they are in the business of building hope are better equipped to know how to listen and encourage dreams.

Training and supporting the workforce. Creating the kind of workforce required to help youth thrive necessitates training, supervision, accountability, and resources that reinforce a culture of high expectations. It involves ensuring that the policies that guide everyday interactions with youth and that provide the foundation upon which services are delivered are informed by adolescent brain development, the impact of trauma on development, and what youth need to flourish. Workers need both skills and support in helping young people to overcome their history and their trauma while not being defined by that history or trauma. Building on and nurturing youth's best qualities, instead of fixating on

their worst traits, is not an easy task. Staff need help in order to assist youth to learn from and even use their lived experiences to overcome adversities. Such an orientation will enable workers to help youth tap into those very qualities that are too often overlooked, or even identified and condemned as part of the youth's problem behavior.

Discovering new service strategies. Agencies need to reexamine their old tool boxes of services and interventions and incorporate some newer models of interventions that are proving useful, not only in addressing trauma but instilling core competencies of self-regulation, executive functioning, and resilience. Such interventions include everything from neurosequencing to play to yoga to music and mindfulness. And services need to be developmentally appropriate for different chronological and developmental age groups. Agencies and organizations should also consider using validated trauma screening and assessment tools. The National Child Traumatic Stress Network has developed a searchable database containing reviews of measures important for screening and assessing children exposed to traumatic stress.[4]

Developing a youth thriving trauma-informed policy agenda. Policies and programs need to facilitate youth participation in activities that promote normalcy. For example, going on sleepovers, participating in afterschool sports and music programs, attending college tours are all activities that youth who are not in foster care take for granted. We need to ensure that youth in care are exposed to the same types of enrichment activities. Agencies also need to reexamine their policies around critical incidents and rewards and punishments so that greater restrictions are not automatically imposed on youth for acting like typical adolescents. Restricting contact with families should never be used as a punishment for acting out behavior.

Engaging and partnering with youth. Services need to be youth-driven. Youth need a voice in creating and driving their case plan based on their own dreams and aspirations for their future. The slogan, "Nothing about Us without Us," needs to define agency culture and practice. Beyond individual case planning, agencies and organizations can establish and support opportunities and forums for youth to take on leadership roles—weighing in on policy changes, governance issues, and decision-making functions that impact young people and their families.

In conclusion, just as parents have always tried to balance meeting both their children's needs and dreams so, too, do all those adults who work with children and youth in child welfare and other youth services. Youth workers can play a critical role in guiding youth's healing from trauma while also equipping them with the protective and promotive factors that will help them to truly thrive.

4 The database can be found at http://nctsn.org/resources/online-research/measures-review

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EVALUATING THE NEED FOR TRAUMA-INFORMED CARE IN A BEHAVIORAL HEALTH SYSTEM OF CARE

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Abstract: Potentially traumatic events (PTE) can occur in the life of an individual and can cause long-term psychological harm, including symptoms or diagnosis of posttraumatic stress disorder (PTSD). A large number of youth currently receiving mental and behavioral health services have been exposed to PTE, and a subset of those struggle with distressing and impairing symptoms of PTSD. Often, these youth have not and will not receive appropriate care, which can include Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and trauma-informed care (e.g., Sanctuary). We sought to identify rates of exposure to PTE and expression of PTSD symptoms in youth receiving services in a system of care and found that 95% of the sample reported exposure to at least one PTE (mean = 5). One third of the sample reported a significant burden of PTSD symptoms (5 or more rated highly in the past month). These findings support the trauma-informed care principle of universal precautions in environments that provide mental and behavioral health services to youth. Case vignettes are presented and implications for practice are discussed.

The description of negative emotional reactions following exposure to a potentially traumatic event (PTE) has a history as long as that of attempts to describe and classify mental disorders more generally (Monson & Friedman, 2006). Modern cognitive behavioral models (i.e., those built on examination of the reciprocal interaction between thoughts, feelings, and behaviors; Beck, 2011) can be used to aid the understanding of these reactions. In combination with decades of research focused on factors that contribute to the origin and maintenance of posttraumatic stress disorder (PTSD), these models provide a context to understand how both children and adults can become psychologically burdened as a consequence of PTE. Functional impairment, for example, has been notable in many individuals exposed to PTE in terms of concentration, memory, mood, sleep, physiological arousal, and the ability to form and adequately maintain social relationships. Although until recently PTSD was classified as an anxiety disorder in the DSM-IV-TR (2000), recent taxonomists now view it as a more complex experience that

involves many different types of emotions and experiences beyond anxiety and anxious arousal (DSM-5, 2013; Riggs, Cahill, & Foa, 2006).

Decades of research have afforded considerable understanding of the disorder, and conceptualizations of its etiology based on scientific evidence are notable (e.g., Ehlers & Clark, 2000). Although other emotions are now thought to play prevalent roles, fear continues to be conceived as the primary emotion driving the development and maintenance of PTSD symptoms. For example, after experiencing a PTE, a child may develop an unhealthy fear related to stimuli that remind him or her of what happened, even if the stimulus is something that would not necessarily provoke fear in another individual. The fear grows stronger when the child mentally or physically avoids salient reminders of the event. In cognitive terms, this avoidance enables short-term reduction of negative emotions prompted by the event while simultaneously reinforcing the idea that such experiences are dangerous or scary. This process can extend to include related stimuli that were not present at the time of the event but because they are similar to the originally feared stimulus (i.e., generalization). Additionally, children may vividly remember feelings and thoughts that they had at the time of the event (e.g., horror, anger, sadness, "I will die,"), and reexperience them in association with their memories of the event, which in turn increases fear and negative reactions to the memory and any reminders (Gonzalez-Prendes & Resko, 2012). In this way, PTSD symptoms emerge and grow over time, becoming more and more impairing in the life of the child. Many distressed youth serviced in publicly funded systems of care are affected by these symptoms but are, ironically, among the least likely to receive appropriate services for their difficulties, as the following example makes poignant:

Case example

Destiny is a 13-year-old female who was removed from her mother's care after being sexually assaulted by her mother's boyfriend. Child Protective Services found evidence of repeated abuse, and she is now undergoing care at a residential treatment center. Destiny struggles with anger and is having difficulty forming positive relationships with either male or female staff members. She is particularly suspicious of the male staff members and becomes hypervigilant whenever one is present. Recently, Destiny was put into a physical restraint after a male staff member startled her while she was in the common area working on her homework. She immediately became physically aggressive, and staff were unable to calm her. Destiny later told her therapist that this situation prompted vivid recall of one of the occasions on which she was raped, which led to her feeling as if she were being attacked again. This in turn led to her immediate reaction of attempting to defend herself, which was amplified when the male staff member placed her into a physical hold. She explained to her therapist that it was only after she was released from the restraint and calmed down that she realized where she was and what had happened. This led to her feeling ashamed about how she had reacted, and to confu-

sion over the enduring nature of her emotional responses to this kind of situation. At the next day's staff meeting, all the staff agreed that they had not realized the extent to which Destiny's prior experience of sexual assault was affecting her currently. Each member of her treatment team expressed strong empathy for Destiny and wanted to help her feel safe in the treatment environment. Their consensus opinion, however, was also that no one knew what to do to help her, neither in terms of specific psychological treatment nor environmental modification.

This depiction exemplifies the type of problems encountered in systems of care, as well as the difficulties inherent in intervention. For example, well-intentioned staff who identify the extremely difficult nature of Destiny's symptoms in the example above do not have a model to anticipate, prevent, or otherwise adjust the environment to address her suffering. Had their facility been structured around trauma-informed care principles, they would have had procedures in place to deal with her behavior in the context of reexperiencing as a symptom of PTSD, and they could have avoided Destiny's retraumatization through use of a physical restraint. Destiny's experience is unfortunately common, however, and the salience of exposure to PTE in youth development and mental health service delivery cannot be overstated. Base rates suggest that up to 60% of community-dwelling children have been exposed to abuse, violence, and other crimes (Finkelhor, Turner, Ormrod, & Hamby, 2009), with much higher rates observed in high-risk samples, such as 93% of youth entering detention (Abram et al., 2004) and 95% of residential treatment (Harr, Horn-Johnson, Williams, Jones, & Riley, 2013). The list of negative social, emotional, and biological outcomes associated with PTE is long and includes delinquency, emotional duress, suicidal ideation, substance abuse, aggre sive behavior, limited educational attainment, memory and learning impairment, alexithymia, serious physical diseases, and fractious social relationships (Adams et al., 2013; Betancourt et al., 2012; Carrion & Wong, 2012; De Bellis & Zisk, 2014; Felitti et al., 1998; Leenarts et al., 2013; Suzuki et al., 2014). Additionally, biological studies of stress impact have demonstrated that serial exposure to traumatic events may increase the negative ramifications of subsequent exposure to PTE (De Bellis & Zisk, 2014).

Given the extremely common occurrence and vast possibility for negative impact, it is clear that the role of PTE in mental health deserves significant attention. This is especially true in instances in which negative reactions to PTE precipitate symptoms sufficiently severe to yield a diagnosis of PTSD. Research indicates that this may occur from approximately 5% (Merikangas et al., 2010) to up to 30% of the time (Runyon, Deblinger, Behl, & Cooper, 2006). Careful attention to accurately identifying these cases will enable appropriate evidence-based treatments to be selected and integrated into other service delivery as appropriate.

Thus, this study focuses on the rate of exposure to PTE in youth presenting to a statewide, comprehensive provider of children's behavioral health services in

the Southeastern United States and the need to integrate a trauma-informed care approach across the system of care. A secondary purpose of the study was to determine the rate of endorsement of symptoms of PTSD in youth who endorsed exposure to one or more PTE.

Methods

Under agency policy, all new clients receive a trauma screen and, where applicable, trauma assessment (Ebesutani, Ale, Luebbe, Viana, & Young, 2011). Data for the current effort were gathered via chart review of trauma screens and assessments as typically administered in the course of clinical care. Charts were produced by 35 licensed, Masters-level mental health providers from across the system of care. These clinicians provided services to 175 youth across a diversity of clinical foci, including services provided through a family preservation and reunification program (49.7% of the sample), intensive in-home services (25.1%), emergency shelters (24.0%), and therapeutic foster care (1.1%). Providers were asked to submit all trauma screens and assessments that were administered over a period of several months during routine clinical practice. The youth treated in this sample of charts ranged in age from 2 to 18 (mean=11) and were 50.3% male, 61.8% Caucasian, 36.4% African American, and 1.8% other minority race or ethnicity.

Trauma screening was accomplished with the Trauma History Questionnaire (THQ), a 15-item self-report measure developed by the Yale Child Study Center Childhood Violent Trauma Clinic. The THQ systematically assesses for exposure to a number of possible PTE. If the child has been exposed to an event, the child is asked to rate how much the event affected him or her on a 5-point scale (*not at all to extremely*) at the time it occurred as well as at the time of the questionnaire. If a client endorsed exposure to one or more PTE, the clinician would administer the UCLA PTSD Reaction Index (PTSD-RI; Pynoos, Rodriguez, Steinberg, Stuber, & Frederick, 1998; Steinberg et al., 2013). The PTSD-RI is a self-report questionnaire assessing frequency of occurrence of symptoms of PTSD in the past month. Although both instruments were originally designed as self-report tools, they were administered as face-to-face interviews in this study. This was due to the low cognitive functioning and delays in educational achievement seen in many clients served by this agency, which may have impaired the successful completion of pen-and-paper versions of the measures.

Results

Ninety-five percent of the sample (n=167) reported exposure to at least one PTE (mean=5, standard deviation [SD]=3.2, range = 0–15). The most common number of traumas reported (mode) was 3. No differences in the prevalence of exposure to PTE were found comparing individuals across age, gender, race, ethnicity, or program of service. Becoming unexpectedly separated from a caregiver was the most common event (67.4%), followed by witnessing interpersonal violence

(60.0%), and being close to someone dying (60.0%; see Table 1 for full results). Interestingly, abuse and neglect were not the most common PTE. Physical abuse was the 5th most common event (41.1%), sexual abuse was 10th (21.1%), and neglect was 11th (20.0%) out of 15 possible events. Given the salience of these events, and their particular resonance in professions focused on promoting adjustment and health in children and adolescents, it is possible that biased estimation may have led one to believe that these events were more common than was observed in this sample.

Thus, in 167 cases the PTSD-RI was administered to determine the severity of impact of PTE on youths' emotional states. Eleven symptoms were assessed with this instrument in terms of acute reactions (i.e., at the time of the event). One hundred eight clients (64.7% of those reporting PTE) reported at least 1 acute reaction. Among those, the average number of symptoms reported was 5 (*SD*=2.6; range = 0–11), while the most common number was 6. A total of 22 possible longer-term symptoms were also assessed in terms of their frequency in the past month. A total of 111 clients (66.5% of those reporting PTE) reported at least one symptom that continued to bother them at least "a little" in the past month. Among clients reporting past-month symptoms, 100 (or 90.0%) reported at least one symptom that bothered them "much" or "most" (3 or 4 on a scale of 0 to 4). The average number of past-month symptoms causing significant disturbance was 6 (*SD*=4.9; range=0–22), whereas the median was 5.

A final analysis involved the frequency of individuals reporting significant long-term impairment due to their previous PTE. This entailed endorsement of 5 or more symptoms on the PTSD-RI at a 3 or 4, which was determined to be a significant burden based on 5 as the mean number of PTSD symptoms endorsed by the sample as a whole and "much" or "most" representing a significant degree of symptomatology. Results indicated that approximately 35% of clients reporting exposure to PTE met these criteria, which represents fully 33% of the overall sample. Put another way, a third of children admitted to this system of care reported experiencing a significant, potentially impairing burden related to symptoms of PTSD. Although not diagnostic, the high frequency and severity of symptoms is telling, and underscores the need for attention to PTE in treatment of youth.

Table 1: Rate of Potentially Traumatic Events (PTE) in Children Receiving Mental and Behavioral Health Services

PTE in Order of Prevalence	n	%
Unexpectedly separated from someone you depend on for love or security for more than a few days	118	67.4
Seen or heard people physically fighting or threatening to hurt each other	105	60.0
Someone close to you died	105	60.0
Witnessed a family member who was arrested or in jail	89	50.9
Someone ever physically hurt you or threatened to hurt you	72	41.1
Someone close to you ever been so badly injured or sick that s/he almost died	71	40.6
Attacked by a dog or other animal	59	33.7
Seen or been in a really bad accident	58	33.1
Watched people use drugs	55	31.4
Someone made you see or do something sexual, or seen/heard someone else being forced to do sex acts	37	21.1
Had a time in your life when you did not have a place to live or enough food	35	20.0
Someone close to you ever tried to hurt/kill self	27	15.4
So sick that you or the doctor thought you might die	21	12.0
Been mugged or seen someone you care about mugged	20	11.4
Been kidnapped	9	5.1

Note. PTE = Potentially Traumatic Event

Discussion

Exposure to PTE was common in this community-based sample and was consistent with previously published examinations of youth in restrictive environments (e.g., residential treatment and juvenile detention). It was notable that the average exposure to PTE (5) suggested repeated intersection with these difficult events. Consistent with previously reviewed studies and models for symptom development, the serial, diverse nature of exposure has contributed to the complex psychopathology notable in this relatively severe sample (Ehlers & Clark, 2000; Hodges et al., 2013). Viewed from another perspective, it is possible the severity of the sample is the reason that substantial previous exposure to PTE was found. Although neither statement is causal, that the experience of PTE was common across almost the entire sample speaks to the importance of integrating appropriate strategies for treatment into the system of care.

Specifically, these findings underscore the need to conduct a thorough assessment for PTE and PTSD symptoms at the beginning of any type of mental health intervention in youth (Kisiel, Conradi, Fehrenbach, Torgersen, & Briggs, 2014), consistent with guidelines from the American Academy of Child and Adolescent Psychiatry (2010). To the degree that interfering symptoms are found, there are several evidence-based treatments available, the most well-researched of which is Trauma-Focused Cognitive Behavior Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2012). Enhancing treatment environments to emphasize trauma-informed

approaches may also aid in attending to PTE in the course of service delivery. Such a universal precautions approach, particularly when applied to extremely severe clinical populations or intensive service settings (such as residential treatment), is designed for clients who have experienced trauma.

This method of adapting service delivery of trauma-informed care across an entire agency is feasible for implementation in large, often chaotic service systems (Conners-Burrow et al., 2013). Additionally, this approach may reduce the likelihood that clients experience treatment-related traumas, a phenomenon that has been well-documented in the literature on inpatient hospitalization and use of seclusion and restraint (Bonner, Lowe, Rawcliffe, & Wellman, 2002; Mohr, Mahon, & Noone, 1998).

Information on trauma-informed care is available from large mental health research organizations (e.g., the National Center for Trauma-Informed Care & Alternatives to Seclusion and Restraint [beta.samhsa.gov/nctic]), and formal models exist to guide organizations wishing to incorporate these ideas. These include Sanctuary (Bloom, 2005), the Restorative Approach (Wilcox, 2012), and Risking Connection (Brown, Baker, & Wilcox, 2012), although there are varying degrees of research evidence to support their usage. The Sanctuary model currently has the most support, while the Risking Connection team is currently gathering data to establish it as an evidence-based practice.

Other notable findings in the current study dovetail with the discussion above, particularly in terms of emphasizing the importance of collecting accurate data and dispelling myths about trauma. For example, abuse and neglect were not the most common traumatic stressors experienced by youth in this sample and were not consistently cited as the most distressing experiences. This was the case despite a large percentage of cases being referred from contexts where these experiences were likely quite common (i.e., family preservation programs). Childcare workers and clinicians working with youth should be aware that many types of experiences may be traumatic to youth beyond the usual suspects, which is an overt component of trauma-informed care models. Additionally, individuals working with youth should be sensitive and wide-ranging when questioning youth about past experiences that may still affect them. Although separation from a caregiver is not a Criterion A event according to the DSM (involving actual or threatened death or serious harm to self or other), it is nevertheless an event that causes great disruption in the lives and relationships of children, and may be experienced as traumatic.

Furthermore, it is important for childcare workers and mental health professionals to understand that trauma may impact a youth on a daily basis. In a cognitive model of emotion, for example, a youth may be suddenly overcome by a distressing memory or flashback, which could lead to physical symptoms of a racing heart, upset stomach, and tense muscles, which in turn could provide the impetus for behavior that appears to be disobedient or oppositional in the course of experiencing the memory. Also, when viewed through a functional framework, a youth

may be unaware of his or her surroundings due to logical, predictable, discernible symptoms of PTSD. Reactions to these behaviors by treatment staff or parents may be softened significantly when they understand what is occurring, which is a component of formal evidence-based interventions (e.g., Cohen et al., 2012) and trauma-informed care more generally.

Case Example Using Trauma-Informed Care

Anthony is an 8-year-old boy who recently came to live with his foster parents, Mr. and Mrs. Smith, with the eventual goal of adoption into the Smith family. Anthony was in a serious motor vehicle accident several months prior to joining the Smith household. He sustained serious injuries and also witnessed adults being critically injured. After a few weeks of Anthony's living with them, Mr. and Mrs. Smith report to Anthony's social worker that they are having trouble with Anthony refusing to travel in the car when it is time to go somewhere. He often refuses and yells "No!" He makes up excuses to avoid being in a car. When Mrs. Smith tries to make Anthony get in the car, he starts to "act funny," like he doesn't know she is there, and if she touches his arm to "get him out of the trance," he angrily runs away from her. Anthony's social worker explains to the Smiths that Anthony may be dissociating, or becoming so involved in a prior memory of his traumatic experience that he no longer fully realizes where he is or what he is doing. She explains that his "disobedient" behavior during these times is best thought of as a result of posttraumatic stress, and not because Anthony wants to misbehave or be noncompliant. She offers the Smiths a referral to a therapist who can provide Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) at a community mental health center that is committed to providing a trauma-informed care environment. The Smiths and Anthony agree to treatment and attend 12 sessions of TF-CBT. After learning about trauma, processing his experience of the car accident, and working through the skills entailed in treatment within the supportive environment provided by the Smiths, Anthony is able to ride in an automobile again without becoming overwhelmed by his memories or fears.

Limitations

The current study does have several limitations. The chart review methodology could have led to biased results in that clinicians may have selectively submitted positive trauma screens and assessments, or may have administered questionnaires only to youth they believed had been exposed to trauma. However, due to agency protocol and study design, we believe this risk to be minimal. An additional limitation of this study is due to the demographics of youth attending the programs where these data were collected. The agency serves a primarily rural, low-income population; therefore, these results may not be applicable to other groups. Furthermore, how these results may apply to traditional outpatient populations is unknown.

Conclusion

The vast majority of youth in this sample had been exposed to multiple PTE, and PTSD symptoms were found to be common. A significant proportion of the sample experienced current distressing and impairing symptoms. It is vital that childcare workers and mental health clinicians be prepared to work with children and adolescents with trauma histories, and trauma-informed care models are recommended for providing a universal and structured approach. Trauma pervasively affects the thoughts, feelings, behaviors, and relationships of youth receiving mental health services, and childcare workers and mental health clinicians must be prepared with sensitive and comprehensive approaches to service delivery.

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Someone ever physically hurt you or threatened to hurt you	72	41.1
Someone close to you ever been so badly injured or sick that s/he almost died	71	40.6
Attacked by a dog or other animal	59	33.7
Seen or been in a really bad accident	58	33.1
Watched people use drugs	55	31.4
Someone made you see or do something sexual, or seen/heard someone else being forced to do sex acts	37	21.1
Had a time in your life when you did not have a place to live or enough food	35	20.0
Someone close to you ever tried to hurt/kill self	27	15.4
So sick that you or the doctor thought you might die	21	12.0
Been mugged or seen someone you care about mugged	20	11.4
Been kidnapped	9	5.1

Note. PTE = Potentially Traumatic Event

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TRAUMA-INFORMED OUT-OF-HOME CARE

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Many children in the child welfare system who live in out-of-home care have histories of complex or recurrent trauma. Children who have experienced complex trauma have significantly higher rates of internalizing problems, posttraumatic stress, anxiety, and externalizing behavior problems. This is certainly true in the Therapeutic Foster Care Program at Community Youth Services (CYS). The children who are referred to CYS's therapeutic foster care program have had multiple out-of-home placements. On average, youth who were referred to CYS's therapeutic foster care program have been in nine previous placements including foster homes, residential treatment programs, extended families, or in-patient hospitals. A significant amount of research exists related to how trauma negatively impacts behavior, emotional development, academic progress, the development of coping skills, and even neurology. Less information is available to caregivers regarding strategies to help children mitigate the impact of trauma, especially toward decreasing problem behaviors or in helping children develop self-regulation skills.

CYS's therapeutic foster care program was intended to serve the most vulnerable children in Washington State's foster care system. These children are defined as needing behavioral rehabilitative services (BRS) foster care due to the challenges they experience in many areas of their lives, including school, home and family, the juvenile justice system, and mental health services. Washington State Children's Administration defines BRS as a "temporary intensive wraparound support and treatment program for youth with extreme, high-level service needs used to safely stabilize youth and assist in achieving a permanent plan or less intensive services." BRS can be provided in residential treatment facilities, foster care homes, and family homes.

In 2009, an intensive effort was made at CYS to identify key factors that supported improved outcomes for youth who qualified for BRS services. Placement stability was determined to be a critical factor, and it was hypothesized that increased placement stability would be essential to improving outcomes in education, namely, academic improvements and behavioral stability, improved mental health, as measured by the Child Functional Assessment Rating Scale, fewer critical incidents, and improved behavior. Another hypothesis was that devoting more resources and support to caregivers would be crucial to improving placement stability. In essence, if caregivers felt supported and were given practical skills to improve placement stability, the youth in their care would do better in many of their life domains.

The Child Functional Assessment Rating Scale (CFARS) is used to measure youths' progress in a number of domains including depression, hyperactivity, cog-

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nitive performance, traumatic stress, interpersonal relationships, danger to self or others, anxiety, thought processes, substance abuse, and behavior problems at school or home. Youth who were discharged from CYS's BRS program between July 2011 and June 2013 demonstrated improvements that ranged from 80% to 100% in the domains measured by CFARS. CYS also tracks placement stability, which is defined as the number of placements that are not disrupted by running away, behavior problems, incarceration, caregiver dissatisfaction, or moves to more restrictive settings. Youth moving into permanent placements or returning home are not considered disrupted placements. The placement stability rate for youth discharged from CYS's BRS services between July 2011 and June 2013 was 92.8%.

CYS staff and caregivers identified a number of areas where they believe improved support would lead to better outcomes. Enhanced behavior management was identified as the most-needed support by caregivers. Many placement disruptions occur because caregivers feel they do not have the skills to deter crisis level behavior.

CYS's staff and foster parents identified a number of skills that have helped youth stabilize and develop improved self-regulation. Caregivers and staff are trained in each of these principles. Caregivers receive home, community, and school-based support and coaching to enhance utilization of the following principles:

- Trauma-informed Adults
- Authoritative Parenting and Engagement
- Understanding the "Test"
- Understanding Self- and Emotional Regulation
- Therapeutic Environments
- Open Environments
- Accountability
- Targeting Sequences of Behavior
- Listening
- Monitoring vs. Supervising
- Collaborating with Schools
- Enhancing Prosocial Activities, Prosocial Peer Relationships, and Prosocial Adult Relationships

Trauma-Informed Adults

Many of the communities in which CYS provides therapeutic foster care have been identified as having high incidents of children and families who have experienced adverse childhood experiences (ACES) (Lobnghi, 2012). Adverse childhood experiences include the following: physical abuse, physical and emotional neglect, domestic violence, familial substance abuse, familial untreated mental illness, sexual abuse, and placement disruptions. Research by the Washington State Family Policy Council demonstrates that ACES can lead to lifelong challenges:

- chronic health problems
- mental health problems
- posttraumatic stress disorder
- substance abuse
- tobacco use
- violence and aggression that lower lifetime productivity
- decreased ability to read social skills and develop supportive relationships
- poor emotional regulation
- isolation
- slower language development and speech delays
- poor verbal and memory recall
- lower cognitive functioning (Lobnghi, 2012)

CYS caregivers are provided training in home case management support and consultation to enhance their understanding of how complex trauma impacts youth. Caregivers' understanding of trauma has been important in achieving behavioral and placement stability. Parents, staff, and families of foster youth are supported in understanding the concepts and skills discussed below.

Authoritative Parenting and Engagement

Authoritative parenting is a child-centered approach in which caregivers have the ability to equally balance acceptance, nurturing, and enrichment with limits, boundaries, and structure. It is important that each caregiver provide these balanced core competencies. It is likely that parents will be polarized if one parent takes on the role of the nurturer and the other takes on the role of the disciplinarian.

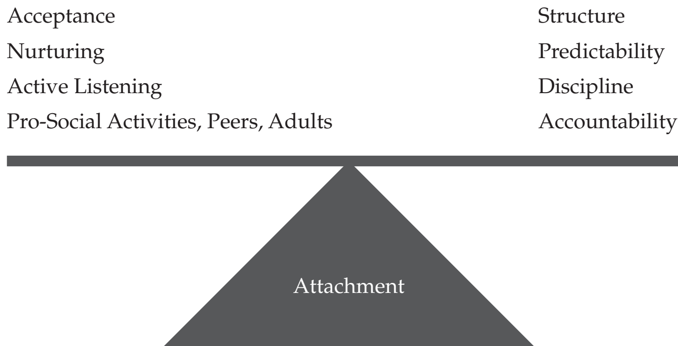

Figure 1

Inherent in authoritative parenting is engagement. Engagement between youth and their caregivers is critical to youth's placement stability as well as to their success in other domains of their lives. Engagement can be difficult to achieve with youth who have histories of being rejected and who have lived in as many as nine or more placements before coming to CYS. Enhancing engagement in out-of home care is particularly challenging for adolescents who demand independence and who are regularly striving to differentiate themselves from adults.

Caregivers and staff are encouraged to understand and employ the following core competencies of engagement:

- Compassion is the caregiver's ability to communicate an appreciative understanding of what it might feel like to feel down, worried, rejected, angry, depressed, or anxious even if the caregiver has not shared the same experiences as the youth in their care.
- Interpersonal warmth and emotional acceptance are critical to the development of attachment. Research demonstrates that when brains detect a positive emotionally charged event, like warmth and acceptance, dopamine is released into a physiological system. Dopamine improves one's memory, information processing, and sense of well-being (Medina, 2014).

Key to authoritative parenting is the ability for caregivers to provide virtually unconditional acceptance to the youth in their care. People will go to great lengths to achieve acceptance. If youth do not find acceptance with their families (birth, extended, foster, adoptive, or chosen) they will find it somewhere else. Many gang affiliated youth and adults acknowledge that they joined gangs for acceptance, not because they wanted to get into trouble. Unfortunately, acceptance into gangs is often measured by the pledge of a new member to commit crimes or hurt others.

Foster parents are supported in understanding that providing acceptance takes time and is not reciprocated right away. Youth sometimes make it difficult for adults to bond or provide unconditional acceptance. It is often the case that youth will push away from adults who try to get emotionally close too fast. A foster parent once stated that providing acceptance is a bit like hugging a porcupine . . . the closer one gets the more likely one is going to get hurt. It is also important to note that acceptance of the youth as a person does not mean that adults have to tolerate that youth's negative behavior.

Research demonstrates that positive attachment and acceptance can positively impact one's brain functioning. "When children are attaching in positive settings, they are literally being wired to become positive people" (Gray, 2007).

Authoritative caregivers and staff must communicate high expectations for the youth in their care. Most youth have had previous experiences where caregivers lowered expectations or ignored minor behavior problems. Lower expectations often elicit escalated behavior. Youth's behavior will continue to escalate, in part, to determine when and how adults will set clear limits.

It is CYS staff's experience that youth who have authoritative caregivers feel safe, are able to more quickly learn self-regulation skills, develop improved social skills, develop better judgment, and become more confident with independence and autonomy.

Understanding the "Test"

Predictably, youth who are referred to CYS's therapeutic foster care program are frequently mistrustful, cautious, and sometimes expecting to disrupt their newest placement. A 14-year-old girl, who lived in more than 15 foster homes and 2 adoptive homes, once stated,"The only thing worse than being kicked out is in not knowing when rejection will happen . . . so I'm going to make it happen."She actually flooded the home of her newest placement by bringing a hose into the house in the middle of the night, turning on the outside spigot and going back to bed. She demanded that her foster family"give up."The foster family was able to maintain her placement, and she went on to graduate from high school and acquired a nursing credential. She continues to have a good relationship with her family and even changed her name to theirs.

Foster families receive support in understanding the meaning of the "test": "Will you replicate what happened to me before?" The test is common with youth who have histories of multiple placements and is especially arduous for youth whose goal is to return to their birth or extended families. The test includes the following:

- Am I safe?
- Are you stable?

- Will you leave or reject me?
- Can I make you leave me or reject me?
- Can I make you angry, frustrated, emotional, or abusive?
- What will you do when you become angry, frustrated, or emotional?
- How will my life change when I live with you?

The test from young people can range from small power struggles to oppositional or defiant behavior to very serious behavior, like physical aggression, running away, or damaging a house, to making false allegations about the adults in their lives.

Passing the test happens over time, sometimes a very long time, by caregivers being authoritative and communicating the following messages:

- I will remain calm and self-regulated in crises.
- I am in control of my emotions, and I will try to help you control yours.
- I will not destabilize your life again.
- I will give you time to trust me.
- I will try to understand your experiences and your feelings.
- I will say what I mean and mean what I say.

Understanding Self- and Emotional Regulation

Research and the experience of CYS staff have shown that many youth referred for therapeutic foster care struggle with self-regulation and emotion regulation. Emotional dysregulation can be variable and is expressed in myriad ways, including but certainly not limited to hypervigilance; excessive worry and anxiety; externalizing behavior (physical and verbal aggression, running away, property destruction, threats, self-hurtful gestures, etc.); and poor judgment. Dysregulation also stimulates the physiological releases of adrenaline and cortisol. If untreated, high levels of adrenaline can scar blood vessels and may cause heart attacks and strokes. High levels of cortisol damage the cells of the brain's hippocampus, harming one's ability to learn and remember (Medina, 2014).

Caregivers are supported in understanding strategies to help youth learn self-regulation. The most critical caregiver skill is demonstrating an ability to be calm and self-regulated, especially when dealing with escalated behavior. It is rarely helpful for adults to match the youth's escalated behavior with their own intense demeanor. CYS staff have observed that adults who can demonstrate calmness and self-regulation can positively impact youths' neurology. Mirror neurons are in the emotional centers of the brain, allowing children to feel some of the feelings of staff members when they are tracking them. It is the experience of CYS staff that

youth will behaviorally and neurologically mirror calm environments and composed adults.

It is important that adults can assess their own triggers for dysregluation. Everyone has emotional buttons that, when pushed, elicit anger, frustration, or exasperation. Youth who have experienced trauma can sense when adults become emotionally tipped over or dysregulated. Youth can sometimes use that personal knowledge to keep pushing caregivers' emotional triggers. Triggers are unique to each adult and can include such things as frequent power struggles, lack of respect, oppositional and argumentative behavior, lack of appreciation, giving up quickly on tasks, and harming pets. Foster parents are asked about deal breakers for keeping a youth in their home instead of asking for a placement change. It is important that adults are not only aware of their personal deal breakers but also the behaviors that prompt them to be emotionally tipped over.

Therapeutic Environments

Therapeutic environments are as important to youth as their connection to self-regulated caregivers. Youth tend to stabilize, feel safer, and function better when many of the following competencies are in place at home. Predictability, routines, and consistency offer youth a sense of positive power and control in their lives, helping them know what to expect in their homes and when changes will occur. Predictability is as important to youth who have experienced trauma as it is for children who are much younger. For example, toddlers developmentally rely on knowing the routines of their family and home. They frequently react negatively to even small changes in their routines. The same is true for youth who have had traumatic experiences in life.

The experience of staff at CYS have shown that organization helps youth stabilize. Organized homes can help youth improve time management, impulse control, and ability to plan for the future. These critical thinking skills promote enhanced reasoning and an improved ability to listen to the opinions of others.

"If it's broke, fix it!" It is common for youth who have experienced complex traumas to have a trail of chaos in their wake. They bump into others, they accidentally break things, they make messes in their environments, and they knock things over. Caregivers find it particularly frustrating when their youth believe they know how things work when, in fact, they break things like televisions, cell phones, and computers. It is also common for youth to take out their feelings of frustration and anger on walls, doors, furniture, and their own or others' possessions. CYS staff have observed a direct correlation between unrepaired homes and more damage. For example, little holes in the sheetrock become gaping holes, and little bits of graffiti become even more inappropriate images on the walls. Conversely, damage that gets repaired lessens further destruction. Youth have a right to live in an environment that is respected and cared for, but they should be held accountable for the damage they cause.

Understanding Power and Power Struggles

Escalated behavior often begins with a power struggle. Tantrums, running away, and verbal or physical aggression often start with youth arguing or making demands that engage their caregivers into power struggles. Understanding the etiology of power struggles and utilizing anticipatory strategies to deter power struggles have proven to be very effective.

Ask typical children what they want to be when they grow up and their answers are almost always the same. They want to be firefighters, police officers, athletes, doctors, soldiers, teachers, their parents, etc. All of those professions have a number of characteristics in common. They are heroes, they are respected, they have power, and they have control. Children will regularly identify with power and control whether those aspirations represent positive role models or negative role models.

Children who grow experiencing trauma may have a much different concept of power and control. Their model of power and control may be someone who abuses others, someone who projects the responsibility for their offensive behavior onto others, including their victims, somebody who minimizes their negative behavior, or someone who threatens others to get their way. Youth who have experienced trauma sometimes use negative behavior to test the strength, resolve, and authority of their caregivers. They may do so because this is how their heroes (perpetrators of their own trauma) garnered power and control by frequently and intensely provoking others to see how they react.

"Power struggles with parents and adults in authority are a normal part of adolescent development because it is during this time of life that young people are beginning to express independence and autonomy" (Whitlock & Purington, 2013).

Parents who try to avoid power struggles actually find themselves in more power struggles with the youth in their care. Managing power struggles has two fundamental strategies.

The first strategy is offering youth as many choices and as much independence and autonomy as safely possible. It is difficult to get into power struggles with people who give others appropriate control over their lives. Even more important is that people like, and want to bond with, people who give them choices in their lives. Anyone can relate to those who work for a supervisor who gives employees reasonable control over their work as opposed to bosses who micromanage employees.

Offering youth many choices is directly related to decreased power struggle behavior. It is important to offer choices that are acceptable with the adults. Choices that, no matter what choice the youth makes, should not negatively impact anyone else. Parents who understand the importance of independence and autonomy are extremely creative in how they offer choices: "You can wear the blue socks or the brown socks," "You can wear one blue sock and one brown sock," "You can

have juice or milk," "You can have a half or a full glass of milk," "You can go to bed at nine or nine-fifteen," and so forth. Although those choices seem trivial, it is remarkable to see how positively youth respond to their parents when they are given many of these kinds of choices every day.

The second strategy in managing power struggles is in implementing the limited number of rigid rules at home. The well-used phrase, "Rules are made to be broken," is basically true. For example, people rarely drive the posted speed limit. If a posted speed limit is 60 miles per hour on a freeway, it is often the case that cars are traveling 65–70 miles per hour. What is the reason? It is human nature to resist rigid rules when people do not understand the reasons for a rule's inflexibility.

Rules

Rigid rules should be implemented primarily to assure health and safety. If children ride bikes, they must wear helmets. If people are traveling in a car, they need to wear seatbelts. Youth who pose a risk to others, or to the community, need to be closely supervised.

Specific strategies are important when implementing rules for health and safety:

- The specifics of each rule should be clearly described. Vague rules or rules that change are not as effective as those that are clear, repeated often, or even visually displayed.
- Why a rule is needed should be clear. Youth have long histories of resisting rules because, in part, they don't know why the rule exists. Caregivers should not assume that youth know the reasons for the rules.
- Rules should be stated by calm adults without elevated emotions, lectures, moralization, and long explanations.
- Rules should be stated positively by telling youth what is expected of them. It is common that children are told what not to do or what adults do not want them to do. Children tend to not hear the word not, but tend to hear only what follows the word do. For example, tell people not to think of an elephant and then ask them what they actually are thinking about . . . most of the time they admit they are thinking of an elephant.
- Rewards should be clearly identified when youth follow the rules. Rewards can range from caregivers subtly acknowledging their good behavior, praising them, or giving them tangible rewards like money, special food, screen time, or later bedtimes.
- The consequences when rules are not followed should be clear. Restorative justice consequences are encouraged. Restorative justice means that when a rule is broken, the youth must do something to repair the impact of the

broken rule. Consequences should be active as opposed to passive. Active consequences are when the youth has a task to repair the impact of the broken rule. Passive consequences are taking possessions away from youth or "grounding" youth. These are not as effective as active consequences.

- Rules should be reinforced 100% of the time by all the adults involved with the children. This is a problem when one parent is more apt to enforce rules, and the other parent might be more apt to be permissive and less emphatic about applying the rules. The same is true when parents enforce the rules but other adults (teachers, day care providers, extended family members, etc.) do not uphold the same standards.

Open Environments

Many children in out-of-home care programs have lived in birth or extended families in which members agreed to keep secrets, including child abuse and neglect, substance abuse, sexual abuse, criminal behavior, and domestic violence. There are compelling reasons for youth to keep secrets, including being afraid, not wanting to disclose unfavorable information about their families, and being loyal to their birth families. These are closed environments in which outside people are not allowed in and little inside information about the family is allowed out. CYS staff encourage open homes and relationships in which all the adults in any youth's life are committed to high levels of communication, collaboration, and cooperation. In fact, the adults' allegiance to openly and positively link with each other has to be as great as their allegiance to the youth they are supporting. Keeping secrets or restricting who can have contact with youth only replicates what happened to youth before.

A youth's multidisciplinary team can include the foster family, the birth and extended family, school staff, social workers, probation officers, and therapists. It is imperative that all of these people are committed to unified plans for that youth and the strategies to achieve those plans. Inevitably the adults on a youth's team are apt to be polarized unless there is a mutual commitment to communicate, collaborate, and cooperate with each other.

Accountability

Many youth understand that their escalated behavior can be viewed by adults as omnipotent. They have learned that they can make adults walk on eggshells around them by just the threat of a tantrum or defiance. Youth also learn that adults may be reluctant to hold them accountable for inappropriate behavior for fear of even more escalated behavior. Four things tend to happen when they act out: they get more therapy, they go to emergency respite, they get more medication, or they get placed into another home or facility.

It is important that youth be held accountable for negative behavior by the adults with whom they are having problems. Youth who are sent to respite, to an-

other placement, or home from school when they have behavioral problems learn that adults are either not competent to address their escalated behavior or are not willing to address those problems.

The phrase “catch your child doing well” really does work! It is important to remember that accountability has the best impact when youth are recognized, acknowledged, and rewarded for positive behavior. Holding youth accountable is most effective when adults give positive attention to positive behavior that is the exception to the problem. For example, rewarding a youth for talking respectfully to others has a greater impact than punishing disrespectful interactions with adults. Rewards can range from tangible benefits like money, more screen time, later bedtimes, serving food they like, or prizes, to more subtle rewards like a smile, a pat on the back, or verbal acknowledgment that the adult noticed the positive behavior. Rewards are most effective when they are utilized frequently (many times per day) and immediately.

A sometimes underutilized reward includes activities youth can do with their foster parents. CYS staff and youth caregivers are encouraged to utilize their own interests and activities to engage youth and acknowledge positive behavior. Those interests and activities can be kicking a ball, playing catch, riding a bike, fixing something, cooking, gardening, learning a new skill together, going on rides in the car, and doing community service.

Establishing accountability strategies for antisocial behavior can be a bit more daunting. Restorative justice requires youth to repair the harm they have caused by their negative behavior and make it right to the person they harmed. Consequences are much less effective when delivered by someone other than the person with whom the youth had the problem. Restorative justice strategies convey to youth that their behavior adversely impacted someone. Identifying the effects of negative behavior is more effective than communicating to youth that they broke a rule. Restorative justice strategies increase responsibility and improved placement stability.

CYS staff and parents are encouraged to proactively identify appropriate consequences before problems arise. Trying to determine which consequence to use in the heat of escalated behavior is less effective.

Active consequences are better than passive consequences. With active consequences, the youth has to do something to make it right or to restore justice. With passive consequences adults take things away from youth or ground them for misbehavior. Taking things away from youth in out-of-home care only replicates what has already happened to them as they have pretty much had everything taken away from them already, including their families. Active consequences can include doing a job or doing something for the person who was negatively impacted by the youth’s behavior.

Consequences are most effective when they are utilized frequently for small behavioral transgressions. Youth learn by the frequency of the consequences, positive or negative, not by the intensity. CYS staff have observed that negative behavior decreases more quickly when multiple, small, immediate consequences are carried out each day. Conversely, negative behavior decreases much more slowly or not at all when parents try to impact behavior with larger, longer-term consequences . For example, having a youth wash one dish as a consequence for not taking their dishes to the sink after dinner is more effective than waiting for days to address the problem by having the youth wash everyone's dishes at a later time.

Consequences should also have a beginning and an end. Lecturing, moralizing, or preaching to the youth about why their negative behavior is not effective because youth rarely listen to those messages. Verbal messages serve only to convey the adults' frustration, which gives the youth negative power and control over the adults in their lives.

Targeting Sequences of Behavior

Youth do much better when adults intervene early in escalating behavior. Targeting sequences of behavior offers youth a sense of safety and skills to cope with emotional dysregulation.

Youth who have experienced trauma struggle with regulating their emotions, coping with stress, and moderating their escalating behaviors. In part, this is due to the high activity of the limbic system area of their brains. Caregivers and program staff are encouraged to intervene early by recognizing and addressing the antecedents of more escalated behavior. There is little evidence that ignoring escalated behavior will result in more stabilized behavior. When behavior goes past a one or two on the scale below, their behavior will go to a ten within the blink of an eye. Antecedents of escalating behavior can be as subtle as rolling of the eyes, a certain posture, a time of day, or even a location. For example, going into a store may be a predictor of escalating behavior if a youth is triggered by being in public. It is important that adults know the signals youth are giving to indicate that their behavior may be escalating on the ten-point scale below.

The best early intervention is to ask youth to "use their words" when the adult observes any predictor of escalating behavior. Encouraging youth to verbally express their feelings becomes an alternative to expressing their frustrations by acting out to get their needs met or to get adults to notice their dysregulation.

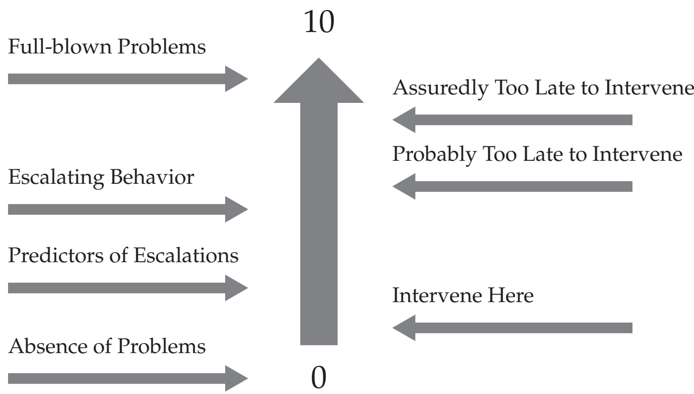

Figure 2

Listening

Youth who have experienced complex trauma have had few adults in their lives who have genuinely listened to them. Instead, they have experienced adults as order-givers who command youth to do what the adult thinks is best for the youth: "You need to go to therapy,""You need to calm down,""You need to stop behaving that way,""You need to try harder at school."

CYS staff and caregivers have identified two styles of adult listening. The first style includes advice givers and correctors. Advice givers primarily focus on problems. They tend to tell youth what they did wrong, and they describe what behavior is more acceptable or appropriate. Ironically, advice givers believe youth are really listening and that their advice will be taken seriously. Correctors are more apt to lecture and preach. Youth tend to hear adult lectures as "blah, blah, blah."

The second style includes active listeners, who focus on feelings rather than behavior. Active listeners also encourage youth to keep talking. Active listeners understand that people, especially youth, listen more to what they themselves are saying than what someone else is telling them. Good listeners focus on strengths rather than problems. They also listen for what worked rather than what didn't work.

Probably the most important strategy in being a good listener is to be curious. Being curious and asking questions convey the message that the adult will truly listen to the youth's experience and how it made the youth feel. Having a curious listener also encourages youth to come up with their own solutions to challenges. CYS staff and caregivers are encouraged to utilize door opener phrases to encourage youth to keep talking. Door opener phrases include "How did that make you feel," "What are you feeling now," "Tell me more," "Hmm," "What else can you tell me about that," "Let's discuss it," " Go ahead, I'm listening," "What do you

worry about," "Tell me the whole story," and so forth. Good listeners are also comfortable with silence.

Adults are also encouraged to regularly ask youth about their worries, understanding that youth in out-of-home care regularly worry about things that most people never have to think about. It can take a while before youth genuinely believe adults will listen and that adults really do care about how they feel. However, it doesn't take long for youth to learn that talking can help solve problems, especially when they have adults in their lives who will truly listen and accept what they have to say.

Monitoring vs. Supervising

Youth who come into the CYS therapeutic foster care program are often under orders that their caregivers must provide line-of-sight or twenty-four-hour, seven-days-per-week supervision. No one can provide that level of supervision. Even guards in maximum security prisons admit they cannot do that. Also, maximum security prisoners acknowledge that they know how to evade line-of-sight supervision in order to have contraband, sex, drugs, and alcohol. Youth will also do whatever they can to elude high levels of supervision because they perceive it as unnecessary and oppressive. They might run away, not come home from school, hide, and become deceptively sneaky to escape line-of-sight supervision. Inflexible supervision fosters youth dependence on adults and does little to support youth learning to make independent decisions.

However, line-of-sight supervision must be applied when health and safety is at risk. For example, youth who are registered sex offenders should only be around younger children while they are in sight and supervision of adults.

Monitoring, different from supervision, is defined by the following:

- Caregivers giving their permission for youth to be on their own in the community when with friends or when participating in social activities;
- Caregivers knowing where their youth are;
- Caregivers knowing what their youth are doing;
- Caregivers communicating with the parents of other youth involved;
- Caregivers establishing timelines for when their youth will check in or be home.

Monitoring offers youth opportunities to learn how to manage independence and autonomy. Almost all youth, especially adolescents, describe wanting freedom, choices, and opportunities to be on their own. Those opportunities can be offered when youth have demonstrated successes in asking for permission, when they are where they're supposed to be, when they check in on time, and when they come home on time.

Collaborating with Schools

Stress at school shows up at home. Many traumatized youth have histories of behavioral challenges and academic deficits at school. This is largely due to that fact that many youth in foster care experience school as an environment in which they are not academically competitive are stigmatized as being different. There are valid reasons why youth who have experienced trauma are behind in school. They start kindergarten at a deficit because they may not have been read to nor have they had opportunities to participate in preschools. As they get older the academic gap between them and their peers often gets wider. It is important that caregivers and staff have compassion for how difficult it must be for youth to be at school in which they experience educational shortfalls and don't match up equally with their peers.

Success at home shows up at school. Children and adolescents become more successful at school, as measured by staying in school, improving grades, and having fewer behavior problems, when they feel safe, engaged with their families, and stable at home.

There is little evidence that youths' school successes are enhanced when their parents mandate remedial work at home in an effort to help the youth academically catch up. Caregivers should be expected to provide time and help with reasonable amounts of homework that is age and developmentally appropriate. Remedial schoolwork, mandated by their parents, deters youth from positively attaching to their parents. Youth see these caregivers as simply taskmasters whose primary mission is to make them succeed in school.

You may have heard the common belief that teachers spend about 80% of their time on 20% of the kids in their classrooms. Many of those 20% have experienced trauma and may even be in out-of-home care placements. Teachers will also state they have little training in working with youth who act out, who are emotionally dysregulated, and who are far behind academically. In an effort to support youth in out-of-home care, caregivers and staff are encouraged to help educators learn about trauma. For example, teachers experience most children to have high frustration tolerance. These students like being challenged and are interested in thought provoking assignments, whereas many of the youth who are in the CYS therapeutic foster care program struggle with low frustration tolerance. These youth frequently give up on trying to solve challenging tasks and school assignments. The Child Welfare Information Gateway (2004) identifies low frustration tolerance as a risk factor for child abuse and neglect.

It is important teachers and school administrators are helped to understand that expelling or suspending youth from school for behavioral problems is not usually effective. As stated above, children should be held accountable by the adults with whom youth have a behavior problem. Suspensions and expulsions give children the message that the school staff members are either unwilling or not capable of dealing with youth. Many youth in out-of-home care programs would rather be

at home than at school, even if there are consequences at home. Having caregivers take on the role of punishers for a youth's problems at school deters the primary goal of foster parents. Staff at CYC want foster parents to focus on engagement, warmth, and compassion to enhance stability rather than be disciplinarians for the youth's behavior or academic problems at school.

However, a positive home-school link is important to overall academic success. The home-school link can help youth's teachers understand what works with particular children. It also includes foster parents knowing about the Individual Education Plan (IEP) process and how to utilize the IEP to assure their children will get the help or accommodations they need to succeed at school. A home-school link conveys to youth that the adults in their lives are positively communicating, collaborating, and cooperating with each other in youth's best interests.

Enhancing Prosocial Activities, Prosocial Peer Relationships, and Prosocial Adult Relationships

CYS has increased its resources for youth, families, and staff to participate in prosocial activities. Some resources were even rededicated from traditional supports like individual therapy and tutoring so youth could learn new skills, be active, and have fun with the significant adults in their lives. Sports, music, arts, dance, climbing, cooking, knitting, volunteering in the community, rafting, skiing, snowboarding, sewing, fishing, gardening, and especially aerobic exercise are examples of the CYS prosocial activities. Improved CFAR scores and improved behavior at CYS seem to be correlated to youth engagement in prosocial activities. Many youth who are referred to the CYS therapeutic foster care program have had few opportunities to participate in or be successful in prosocial activities. Caregivers are encouraged to utilize their own interests, activities, and hobbies to enhance engagement and to keep youth active. Prosocial activities have to be individualized based upon the chronological age, emotional age, and self-regulation of the youth. Certainly not every youth is ready to play competitive sports, but most youth can go to a public pool to swim or go on a walk or ride a bike with someone in their family.

Physical exercise with and for youth is emphasized at CYS. According to research by Medina (2014), "Physically fit children identify visual stimulus much faster than sedentary ones. They appear to concentrate better. Brain activation studies show that children and adolescents who are fit allocate more cognitive resources to a task and do so for longer periods of time."

One of the biggest contributors to a youth's behavior are their friends. Youth who come into CYS's therapeutic foster care program often describe themselves as having friends. However, when asked if their friends make their lives better or worse, they frequently acknowledge incidents where they have gotten into trouble with their friends. It is common for people to be attracted to others who look like them, share the same interests, think like them, and behave like them. Youth who have experienced trauma are no different. They tend to gravitate to peers who have

similar behavior, language, and demeanor. Caregivers and staff should monitor the friends of their youth. It is even more important for caregivers to develop strategies that will encourage young people to engage with friends who are positive influences on their lives. Engaging youth in prosocial activities is one way of helping foster youth meet prosocial peers. Preliminary research at CYS shows a direct correlation between increased prosocial activities and decreased critical incidents such as, running away, being aggressive, and having behavior problems at school.

Caregivers and staff should also be encouraging youths' relationships with adults who will improve their lives. Permanency for youth is defined in two ways. One definition is family on whom youth can rely for support throughout their lives. The second definition is when youth are connected with an adult who will follow that youth through life. Prosocial adults can be coaches, neighbors, extended family, educators, friends, Big Brothers, Big Sisters, and clergy. It is important that youth are positioned to develop relationships with those prosocial adults.

Conclusion

People who have a job can tell one what they do. People who have a profession can tell one why they do it. Any profession requires ongoing learning, training, and practice. Doctors, teachers, lawyers, and athletes acknowledge they will never know everything about their work. All professionals have to participate in continuing education and training.

Positive outcomes at CYS are, in large part, due to caregivers and staff professionally embracing this second set of parenting skills. Caregivers also understand that their practice is doing the same things over and over, sometimes hundreds of times. Rarely does one intervention, discussion, or strategy result in a significant change in behavior or functioning.

Yet, these skills can support youths' success in many of domains of their lives. Placement stability at CYS is over 90% as a result of parents embracing and practicing these skills. The CYS foster family retention rate also increased when parents felt trained and supported in implementing these skills. Youth who come into CYS homes recognize that their caregivers are experienced, competent, and confident.

CYS caregivers respect youths' birth and extended families. They work hard to engage the youths' families, when appropriate, with the knowledge that their youths' allegiance and loyalty to their birth families is unshakeable.

Staff and foster parent retention is also an important factor in placement stability. Youth who come into care at CYS know that the adults with whom they are working have experience with youth who are similar to themselves. CYS's therapeutic foster care program staff retention rate for the last 10 years is 5.3 years, while CYS current foster family retention rate is 5.5 years.

Much is written about how vulnerable caregivers are to vicarious or secondary distress that comes with working with youth who have experienced trauma. Much is also written about ways caregivers and staff should practice self-care to

deter the impact of vicarious trauma. CYS staff encourage caregivers to develop a support system that is natural and community based that includes friends, neighbors, clergy, and work colleagues. These community supports are as important as professionally based advocates like staff, case managers, and therapists.

CYS encourages parents to maintain a clear sense of their own adult identity. Caregivers are supported in continuing with their own hobbies, interests, and activities outside of parenting responsibilities. CYS staff utilize financial resources to support caregivers' interests and activities and to provide proactive respite care so adults can emotionally refuel.

CYS staff believe that resilience is defined as one's ability to meet challenges, survive, and do well despite adversity. Resilience is the capacity to bounce back from a history of trauma. Youth can learn resilience by feeling safe and by being engaged with adults who are self-regulated. Resilience is also enhanced when youth live in stable placements without fear of having to continually move.

CYS staff collaborate with Native American tribes in the Pacific Northwest, who advance the importance of the "Circle of Courage." Youth will do well when they sense their own competence in the domains of the "Circle of Courage" (Brendtro, Brokenleg, & Van Bockern, 2005).

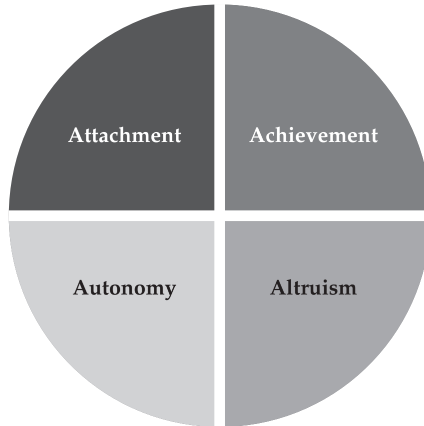

Figure 3

The goals at CYS are that every youth will feel bonded and safe, be able to master tasks and learn helpful skills in life, be independent and utilize good judgment, and give back to their communities. In other words: attachment, achievement, autonomy, and altruism.

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TRAUMA-INFORMED CARE PRINCIPLES AND PRACTICES AT A RESIDENTIAL FACILITY FOR ADOLESCENT GIRLS

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Creating a trauma-informed, safe environment for residents who are survivors of traumatic events and abuse is the focus of care and treatment at Lad Lake St. Rose Youth and Family Center. Trauma-informed care is embedded in the organizational philosophy, the training of all care staff, the intake processes, and treatment principles.

Background

St. Rose was founded in 1848, making it the oldest social service agency in Wisconsin. St. Rose joined Lad Lake, Inc., in 2010 and is comprised of a residential program, an onsite school, male and female group homes, and a stabilization unit. Lad Lake St. Rose Sienna residential unit serves adolescent females, ages 12–17, experiencing physical, behavioral, emotional, and psychological problems such as self-abuse, trauma-abuse, neglect, delinquent activity, running away, school failure, inappropriate sexual activity, anger control issues, and other mental health issues including depression.

Of the 30 females who were served in the residential unit during the time period of January 2013–June 2014 (18 months), 50% were African American, 30% Caucasian, 13% multiracial, 3% Latina, and 3% Native American. The average age upon admission was 15.1 years, with ages ranging from 13 to 17. Most of the residents had been in prior and often multiple placements before coming to Lad Lake St. Rose. The 30 residents had been in an average of 7.8 placements prior to admission. These include group homes (47%), hospitalizations (37%), secure detention (43%), residential facilities (27%), secure juvenile correctional facilities (20%), shelters (17%), foster homes (13%), stabilization units (3%), with other family members or relatives (3%), and rehabilitation facilities (3%). The girls served by Lad Lake St. Rose were more likely to have had traumatic experiences, including multiple forms of abuse and neglect as well as family dysfunction. Twenty of the 30 residents (67%) reported sexual abuse, 25 (83%) reported physical abuse, and 18 (60%) reported both physical and sexual abuse.

Guiding Philosophy

A key component of the trauma-informed care philosophy of St. Rose is the use of nonviolence in all interactions with residents. Residents are encouraged to make decisions of their own volition and not because they are afraid of being punished or because they are being physically forced to do so. According to the National Alliance on Mental Illness (2003), restraint and seclusion have no therapeutic value and

should only be used as emergency safety measures because restraint and seclusion can be detrimental to those who have experienced trauma. Many residents have been restrained during assaults and at prior placements. Restraining a resident or secluding her in a room with no stimulation or assistance can retraumatize her and make her more prone to flashbacks. Physical intervention is used only as a last resort to protect the resident or others. St. Rose is one of the only licensed residential facilities in Wisconsin that does not have a seclusion room. In contrast, according to a recent study, 76% of residential treatment facilities for children had secluded and restrained clients in the previous year (Ramirez de Arellano, Lyman, Jobe-Shields, George, & Dougherty, 2014). Alternatively, Lad Lake St. Rose provides residents with low stimulus rooms, walks with staff, a planned serenity garden onsite, and the availability of art activities. Residents are able to participate in religious activities on a weekly basis, such as attending church services, spiritual groups, and Native American smudging rituals. Debriefing sessions with the therapist are also conducted.

Training

All direct care staff, including youth care workers, the nurse, and the teacher, receive trauma-informed care training to provide insight into those who have experienced trauma and how it influences their thoughts, feelings, and behavior. Training includes nonviolent crisis intervention provided by the Crisis Prevention Institute and Risking Connections, which presents a relational framework, RICH (Respect, Information-sharing, Connection, and Hope), and skills to use when working with survivors of traumatic experiences.

The residential therapist has a certificate in trauma counseling. General staff training on topics such as family relationships and sexual exploitation is trauma-informed as well. Training provides staff with an understanding of the stigma of abuse and its effects on the resident, the reasons a resident may react to certain situations in a particular manner, and the help needed to prevent her from going into crisis.

Intake

Screening for past traumatic experiences is completed using the Adverse Childhood Experiences (ACE) tool and an initial suicide assessment. The ACE tool reveals the client's current thoughts, reactions, and dysfunctions (sleep, appetite, and social relations), and the presence of posttraumatic stress symptoms. The higher the score (on a scale of 1 to 10), the greater the exposure and the greater the risk of negative consequences. The initial suicide assessment addresses past and current self-harm behaviors, thoughts of suicide, past suicide attempts including the method used, AODA concerns, risky behaviors such as delinquency and running away, and risky sexual behaviors. The suicide assessment explores the career aspirations of the client, which speaks to a sense of future. This conveys whether the client feels hopeful

or hopeless and indicates whether the client believes that she has the capabilities and resources to live a productive life as an adult.

The assessment by the therapist also includes exploring the client's family history with her, including her parents' or guardians' backgrounds, legal issues, mental health concerns, and AODA issues. This provides key insights into the client's past experiences and any sources of trauma. It is important to know if the client's parents are still in her life and if her parents or guardians are a reliable and stable presence. The care plan is developed with the understanding that the youth care workers will partner with the family in the treatment of the client.

The client's individualized plan identifies triggers and soothers. Knowing situations, people, and even times of the day that may trigger a strong emotional reaction in the client and subsequently that may help her to calm down provide important insights into the client's thoughts, feelings, and behaviors. Triggers and soothers are discovered by self-report and through observation by youth care workers. All youth care workers and other direct care staff must be aware of the client's triggers and soothers, especially since the client will often be triggered on the unit or in school.

Treatment

Residents participate in individual therapy sessions twice weekly and group therapy four times weekly. Equine, art, and health therapy groups are provided weekly, and most residents participate in family therapy. Residents also meet with a child or adolescent psychiatrist to monitor psychiatric medications during their placements. Residents receive round-the-clock care from youth care workers and have opportunities for recreational activities with program peers, both on the unit and in the community.

Therapists use a strength-based, empowerment approach to treatment with the intention of encouraging clients to become survivors, not victims. Therapists emphasize their role in providing assistance and support to clients and guiding them in making the necessary progress to move on from residential treatment and to ultimately succeed in life.

Symptoms of past trauma and neglect can result in clients' being unable to trust others and feel threatened by them. Special care is taken to ensure that the therapist's office is a safe and stress-free environment. There are no interruptions by phone or visitor. Due to the physical layout of the office, the door can be left open, but the session is not visible nor audible to anyone in the hallway. This is beneficial because some clients experience panic or anxiety in an enclosed room with another person. Toys and trinkets are available to provide tactile stimulation and reduce anxiety.

Therapists employ trauma-focused cognitive behavioral therapy (TF-CBT) techniques with children and adolescents who have had traumatic experiences, and research has validated the effectiveness of TF-CBT for this group. For example,

a study of children who had experienced sexual abuse and were treated with TF-CBT showed overall improvement upon completion of treatment and at 6 and 12 months after treatment (Mannarino, Cohen, Deblinger, Runyon, & Steer, 2012). In another study, traumatized children were treated with either TF-CBT or TAU. Lower levels of posttraumatic stress symptoms, depression, and general mental health problems were reported in the children who received TF-CBT (Jensen, et al., 2014). As defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), TF-CBT includes skills in psychoeducation, and parenting, relaxation, affect expression and regulation, and cognitive coping. It also includes developing a trauma narrative using in vivo exposure, attending parent and caregiver-child sessions, and enhancing safety and future development.

A TF-CBT treatment scenario involving a client who experienced sexual abuse would begin with psychoeducation, which provides specific information about the traumatic event experienced by the client. It would include information about the types of sexual abuse, why it may occur, who may be a perpetrator, how the abused person may feel and behave such as in a sexualized manner, and why the abused person would be reluctant to disclose the abuse. The therapist demonstrates relaxation techniques starting with basic but very effective controlled breathing and has the client practice them. The technique of thought-stopping is also introduced. The client is instructed to close her eyes and think of an intrusive experience. This does not need to be the most vivid or upsetting memory of the sexual abuse. After ten seconds, the client is taught to stop the thought by saying "stop" or snapping a rubber band that is around her wrist. Then the client works on replacing the intrusive thought with one that is pleasant.

The teaching of affect expression and regulation is another component of treatment. In this case the client identifies as many feelings as possible. Then the therapist helps the client to rate and differentiate between different degrees of intensity of a particular emotion. The next step is to teach the client how to express feelings appropriately in various situations. Role-playing is a good strategy in which both the client and the therapist demonstrate ways in which they have expressed feelings in real-life situations. Each role-play is reviewed, and if necessary, the therapist and client discuss different strategies for expressing feelings more appropriately.

The therapist guides the resident in creating a narrative of the sexual abuse. The narrative can be in the form of a book, picture, song, or poem. It may be necessary to do this in stages if the client is having difficulty coping with the process. The narrative is read, recited, or sung several times during subsequent therapy sessions. The resident should begin to experience progressively less extreme emotional and physiological reactivity. During the trauma narrative exercise, cognitive processing techniques are used to explore and correct cognitive distortions and errors. The therapist challenges unhelpful or inaccurate cognitions by using progressive logical questioning, also known as Socratic questioning. The questions draw

out the inaccurate cognitions to their logical conclusions, which in most cases are undesirable or even silly.

In terms of safety and future development, clients are able to practice remaining safe in the community by going on unit outings. They also have the opportunity to interact with a diverse set of preapproved individuals who are part of Lad Lake St. Rose so that they can practice social skills and appropriate interactions.

Family therapy is an essential component of treatment. During the initial meeting, the therapist explains her role and intentions to the parents or guardians, which is to offer assistance to the family in addressing past and current issues. During therapy, the therapist serves as a mediator, especially since communication is often at the center of issues between the client and her parents or guardians. Parents and guardians are provided with psychoeduation as well, which is to assist them in helping their children. For example, the therapist teaches the parents and guardians how to use praise. Parents and guardians usually believe that they praise their children frequently, but they are often more likely to criticize their children for undesirable behavior than to praise them. Therefore, the therapist teaches parents and guardians to focus on actively praising the child for desirable behavior and ignoring undesirable behavior such as angry or defiant statements or body language, when it occurs, unless it is potentially dangerous. The therapist prepares the parents and guardians for family therapy by instructing them to use praise and ask open-ended, nonthreatening questions. They are also prepared to respond to the client's trauma narrative and are encouraged to rehearse responses to questions their child may have.

Even with preparation, family therapy can be tension-filled. Past issues may come to light that can make the parents or guardians embarrassed and resistant to addressing and processing. Parents and guardians may have personal issues such as financial problems, addiction or AODA issues, or their own mental health concerns which have impacted their relationship and any past treatment with their child. Parents and guardians tend to be protective and may be in denial regarding the actions of their child or worry that their child's actions reflect poorly on their parenting. Parents and guardians may not trust the therapist and be concerned that the therapist may provide information to the court system which may have a detrimental effect. Since it is the therapist's role to recommend how long the resident should remain in residential care, she can dictate how long the child must be separated from her parents or guardians. This can be another source of anxiety for them.

Communication between the parents or guardians and youth care workers is vital. The resident's confidentiality must be maintained while providing adequate information to the family on the progress the resident is making and any concerns that have developed while in residential care. This becomes important when the resident begins home passes. Having a strong and open communication established with the family before the resident goes home on pass will increase the likelihood that the parents and guardians will feel comfortable sharing what they

observe during the home visits, asking for assistance with issues that may be occurring on pass, and noting any changes they may be seeing in their child.

Team meetings comprising the therapist, nurse, manager, clinical coordinator, educators, and youth care workers are held weekly. This allows the team to discuss the resident's progress and any concerns. This is essential in getting a complete picture of the resident and brings to light issues that could not be detected by the therapist alone. Therefore, all members of the care team must be involved and cognizant of issues that have resulted from past trauma. The therapist must have a positive relationship with youth care workers, which is essential to open communication and effective treatment. The resident's issues and concerns are addressed and processed in therapy for a short period of time each week.

Much of the resident's necessary change and development occurs on the residential unit and in school. Much of the real work happens on the unit and in school. The therapist also is present on the residential unit and observes the residents in school to gain an understanding of their overall functioning.

Youth care workers are in contact with the residents and provide 24 hour care to them. Trauma-informed care principles and practices are employed during each interaction that youth care workers have with residents. An awareness and understanding of the personal history and background of the resident, including any instances of trauma, are vital especially since these past experiences can affect both mood and behavior. When the youth care workers know the possible reasons and motivations for moods and behaviors, they are able to work to address them from a therapeutic standpoint rather than a punitive one. This is much more beneficial to the residents and much more effective in the successful treatment of them. Youth care workers are also sensitive to particular events, activities, or circumstances that may be impacted by past trauma. For example, bedtime seems to be a particularly challenging time. Many residents will become defiant and combative because this is typically the time when they were abused. Additionally, residents will often awaken in a terrible mood due to nightmares from the night before. Past trauma has a profound effect on the resident and all aspects of her life, and therefore, youth care workers' trauma-informed approach is essential.

Translating the principles of trauma-informed care into practice is a necessary component of the successful treatment of the clients at Lad Lake St. Rose Youth and Family Center so that they are able to heal, gain self-esteem, and develop the skills necessary to become productive members of the community.

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TRAUMA-RESPONSIVE ENGAGEMENT AND TREATMENT (TREAT): THE NEW YORK MODEL

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This article will outline a conceptual framework for Trauma-Responsive Engagement and Treatment (TREAT), which can be implemented as a model for organizational and programmatic transformation in a juvenile justice system. The proposed TREAT framework is designed to create juvenile justice programming that is not only trauma-informed, but is actually trauma-responsive with respect to all of the members of its community. That is, TREAT staff identify and respond to the outcomes of traumatic experiences in order to help people recover. They work to increase emotional and behavioral self-regulation of participants and help them to achieve self-identified goals. The article will discuss the evolution of this model in the context of recent and historical forces that have fueled juvenile justice reform efforts nationwide. The article will also describe how systemic changes in reaction to those forces should include a clear understanding of, and response to, the impacts of trauma on youth, staff, and systems, and will emphasize that true systemic transformation requires a model which engages, motivates, and benefits all members of a juvenile justice service delivery system—staff and youth alike.

Keywords: trauma, juvenile justice, treatment

A Model for Organizational Transformation and Service Delivery to Youth in Juvenile Justice Care

Juvenile justice systems across the United States are undergoing changes in the way services are conceptualized and delivered to the youth in their care. Over the past decade, philosophical, moral, ethical, economic, political, and practical pressures to reexamine how the needs of youth in juvenile justice are identified and met have fueled reform efforts nationwide (Patterson 2012).

In contrast to traditional programming for youth in juvenile justice care, which focused on meeting basic needs in a program with a correctional or incarceration design, philosophical shifts have included an emphasis on broader screening, assessment, and active treatment of the mental health needs of youth in care. This includes routine and thorough examination of internal and external factors in the lives of youth and their families that may have contributed to their current circumstances, for example, mental health issues, substance abuse problems, trauma history, poverty, and other functional barriers (Shufelt & Cocozza, 2006). The concept

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of service delivery has appropriately, and necessarily, broadened to include family members, community partners, and any other identified supports for youth in juvenile justice care (Rozzell, 2013). This expansion not only increases the likelihood of successful service delivery while youth are in active care but also has the practical outcome of sharing the responsibility for services and follow-ups among other committed parties following transition to another setting.

An outcome of the focused attention on assessment and treatment of the mental health needs of youth in juvenile justice care has repeatedly confirmed high prevalence of significant mental health, substance abuse, and trauma issues. Mental health problems in youth in juvenile justice care are well-documented to consistently be at higher prevalence (50% to 60%) than the general population (15% to 25%) and indicate a need for significant interventions (Grisso, 2008). Regarding substance abuse issues, one study reported that 78.4% of the 2.4 million youth arrested in 2000 were either under the influence of drugs or alcohol at the time of arrest, had drugs or illicit substances in their system at arrest, were arrested for a drug-related crime, or self-reported having substance abuse issues (Horowitz, Sung, & Foster, 2006). Estimates of trauma exposure from surveys and assessments of youth in juvenile justice care are as high as 90% for the experience of a single traumatic incident (Abram et al., 2004) and 50% or more for a full diagnosis of posttraumatic stress disorder (Wolpaw & Ford, 2004). Thus, in addition to often comorbid issues in mental health and substance abuse, trauma represents a critical health and mental health issue for youth in juvenile justice care.

There is widespread recognition of the unacceptable outcomes of the use of physical interventions in residential juvenile justice, for example, youth and staff injuries, traumatization and retraumatization of youth and staff, and ongoing negative impacts on the overall program environment (Holman & Zeidenberg, 2010). These problems, in conjunction with the increasing awareness of how the experience of trauma impacts youth throughout development, have led practitioners to seek alternative, trauma-informed program models (Kerig & Becker, 2010; Griffin et al., 2012) for residential care and service delivery. These models equip staff to interact with youth in ways that are both effective in maintaining program safety and also promote emotional growth and recovery from trauma.

Many jurisdictions have also witnessed the closing and "right-sizing" of juvenile justice service delivery systems. In particular, juvenile justice residential service systems have shrunken while community-based systems have seen growth. This is entirely sensible given lower overall rates of juvenile crime and arrest, high expense associated with residential care, and treatment-driven decisions to serve youth in their home communities (USDOJ/OJJDP, 2013; A.E. Casey Foundation, 2013). Despite this overall positive movement toward community-based service delivery, systems often struggle to find the right balance in their service delivery systems.

Thus, some jurisdictions have the goals of reducing use of force with youth,

moving services when appropriate to youth's home communities, and broadening service need assessment and delivery to include family and community supports and to treat complex mental health problems. To accomplish these things, they are attempting to change both practice and culture. Internal and external changes to juvenile justice systems, even when movement is in a positive and healthy direction, create stress on the system and on the people within it. The creation and maintenance of a safe, healthy environment for both youth and staff are critical for such expansive, inclusive changes to be successful and sustained.

Trauma-Responsive Engagement and Treatment

Trauma-Responsive Engagement and Treatment (TREAT) is offered as a strength-based, trauma-responsive model. It addresses the service delivery environment as a whole, offering change in both practice and culture. It emphasizes the engagement and safety of every member of the juvenile justice service delivery system community: youth, family members, and staff.

TREAT uses three interdependent foundational concepts to provide the basis for positive growth and development of all of the members of the program community. Each of the three concepts (safety, skills, engagement) is fundamentally reliant upon the other two, and a successful implementation of TREAT relies on an understanding and commitment to each of them.

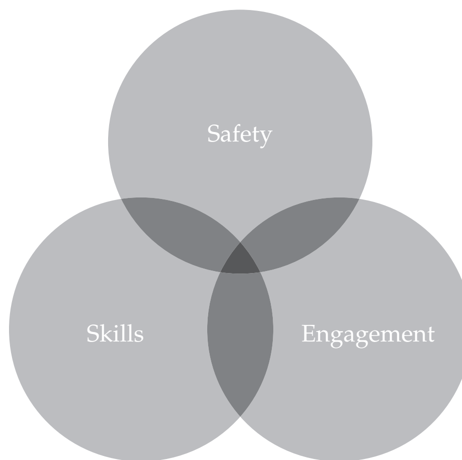

Figure 1: TREAT Model Foundational Concepts

Safety

The first foundational concept is safety. In order for youth to grow or develop in a positive and healthy way, they must first feel safe. In the absence of safety, psychological and physical defenses prevent individuals from connecting to one another and from being able to practice new behaviors and strategies for dealing with problems in healthier ways. TREAT uses a program for trauma-informed organizational change that broadens the conceptualization of safety to include psychological and physical safety (Bloom, 2003, 2005; Bloom & Sreedhar, 2008). The creation and maintenance of a safe environment requires an understanding of how the experience of trauma can impair youth's personal experience of safety even in an outwardly "safe" environment, and cause unsafe feelings. Thus, trauma can lead to unhealthy outcomes for them and for others around them.

Understanding trauma and its impacts on emotions and behaviors can create a framework from which both youth and staff behavior might better be understood. A trauma-informed program includes the idea that individuals are not presumed to be oppositional, defiant, or delinquent, and unexpected, disruptive, or even dangerous behaviors are considered through the lens of trauma to provide an understanding of behavior prior to responding. Other important trauma-informed principles include the idea that people are supported when they struggle, even when their struggles are disruptive and the idea that consequences are fair, not solely punitive, and are tied to restoring safety to the community.

Trauma-informed programming helps staff understand the impact of trauma on human development, their own and their charges'. It also provides a useful context in which to consider current youth behavior in light of formative and often traumatic experiences. Psychobiological theories and research show how behaviors that might appear impulsive or aggressive can be understood as an effort by a traumatized person to maintain their experience of safety, for example, a startled response or an impulsive pushing away. Helpful concepts include reactivity; over-response to seemingly benign or minimal stimulus; reenactment, emotional and behavioral dysregulation triggered by reminders of previous trauma; and triggering, provocation to action and reaction via restimulation of traumas. These assist staff in understanding the youth whom they serve and the behaviors and emotions that are not otherwise expectable or predictable. For example, someone comes up unexpectedly and quickly behind a youth who responds with a curse-laden verbal barrage and a haymaker swing of their fist toward the other person. The youth might have once been considered impulsive, aggressive, or violent. While the outward behavior might be characterized that way, that limited understanding of behavior will likely lead to a very narrow, inaccurate, and ineffective type of intervention, namely, to treat the impulsivity or the aggression. If one also considers a history of trauma, the intervention possibilities expand significantly when the behavior is viewed as an attempt to create and maintain safety. In addition, the former interpretation of behavior quickly leads to the presumption of volition and

subsequent hypotheses about defiance and authority issues, usually resulting in power struggles between staff and youth. The latter, trauma-informed interpretation allows staff to avoid a power struggle around presumed compliance, to be non-judgmental about the behavior, and to try to understand the youth as a whole person in the context of their unique experience of the world.

Staff are also challenged to apply their understanding of trauma to themselves and their colleagues with the same compassion and understanding required when working with the youth in their care, for example, to understand how a coworker disappeared during the exact times of a late night youth group disturbance and reappeared right after it was resolved. Without trauma-informed training, staff often personalize, misinterpret, and imbue defiance and oppositionality into the behavior of traumatized youth, and they can also misinterpret and respond negatively to the trauma-reactive behavior of their peers.

In the TREAT model, safety is not *solely* equal to the absence of violence or aggression, which is necessary for safety. Safety also includes the ability to think, experience, and express genuine affect without hurting others, engage others without violating boundaries, be vulnerable without fearfulness, be empowered without abusiveness, and be present and functional while able to manage difficult emotions such as anxiety and fearfulness.

Previously, many systems of care in juvenile justice care settings have relied on achieving safety via the exertion of authority and ultimately physical superiority. That is, safety is obtained by being more physically powerful and therefore in control of the environment and of the youth in it. Behavior management strategies that use authority in this way simply isolate and suppress problem behaviors and are typically only effective in specific settings, which means the results are not generalizable. So a youth who complies with expectations in a residential program but who is under the threat of physical intervention is unlikely to have learned a new positive skill to substitute for a problem behavior and is unlikely to maintain compliance once the threat of physical intervention is removed. TREAT is designed to dispel the illusion that anyone actually controls anyone else. An important goal of any well-designed rehabilitation program is the promotion of the emotional and behavioral self-regulation of those in care. Self-regulation is the most effective and long-lasting means of achieving safety and the broadest, and perhaps most valuable, therapeutic goal: successful transition of youth to the community and toward future successes, regardless of the setting in which youth may find themselves.

The TREAT model is based on safety via relationships. Staff communicate clear structure and facilitate appropriate consequences in the context of their engagement of youth. Consequences are framed and understood as learning opportunities, and staff strive to use the reinforcement of new, healthy, skillful behaviors whenever possible and in preference to the punishment of negative behaviors, which only suppresses them. This strategy both empowers and engages individuals who form communities of individuals who live, work, and grow together in

residential facilities in units or cottages.

Skill Acquisition (Skills)

The second foundational concept of TREAT is skill acquisition, or simply skills. In order to increase self-awareness and self-understanding, to manage the emotional and behavioral dysregulation that can result from trauma experiences, and to deal with people effectively and safely, individuals need skills. Ultimately, the self-regulation of emotions and behaviors empowers individuals to actively work toward self-determined goals. TREAT includes a cognitive behavioral skills-building and reinforcement treatment program, delivered in group and individual formats, to enhance the skill sets of youth and staff with respect to interpersonal effectiveness, distress tolerance, emotion regulation, and mindfulness (Linehan, 1993, 1993, 2000; Trupin, Stewart, Beach, & Boesky, 2002). Groups are delivered by trained staff who are the primary caretakers for youth. Thus, as direct care staff develop healthy, goal-focused relationships with youth, they also learn and use the same skills they train and reinforce in youth.

A strength-based assessment of youth assets, skills, and abilities, and thoughtful development of the youth and family's self-identified goals form the basis for the identification of the particular skills that will be offered, taught, and reinforced. Although all youth may learn many skills, the youth's individualized plans identify the particular skills expected to help particular youth reach their goals.

A Strength-Based Approach to Assessment

In the historical model for juvenile justice service delivery, assessments were typically deficit-focused. That is, they identified problems, limitations, vulnerabilities, and challenges to the youth in care and their families. While these issues cannot be ignored, the TREAT model is designed so that change cannot occur successfully if the support system does not identify the strengths and resources that youth and families already have and must then use to build new and refined competencies and skills. Staff accept that they cannot build on a deficit or a limitation and therefore must focus on identifying assets and strengths for the youth and their family members. Historical assessments often focused in a narrow and limited fashion on the changes that the youth needed to make, regardless of other systemic factors and variables. The TREAT model expands the assessment to include family members and other resources for the youth so that their contributions can be accumulated in service of the youth and family goals.

As mentioned, assessment in the TREAT model starts with an evaluation of strengths, assets, and resources but does not ignore challenges or vulnerabilities. The latter issues become apparent when the youth's goals and aspirations are considered in light of their skills and abilities. The areas that require supports, services, and interventions become apparent when the support team considers how they will assist the youth in getting from their current situation to their stated

goals. The gaps become apparent and then become the targets of the plan that will match the needed services, supports, and interventions with the existing skills to overcome the challenges and vulnerabilities and to accomplish the youth's goals.

This concept is taken even further in TREAT. An implementation goal is to use valuable concepts at a systemwide level. An informal motto of the TREAT program is, "If it (i.e., process, system, concept, assumption, strategy) is good for youth in care, it is good for staff as well." As such, staff supervision, referred to as coaching, is strength-focused in the TREAT system. Staff strengths are identified, their goals for their performance and career path are developed between them and their supervisors, and they actively engage supervisors in plans for professional development. Like the youth assessment component, staff challenges or deficiencies are not ignored, but become clear through a feedback discussion of strengths and goals.

A Motivational Approach to Goal Setting

In the TREAT model, goal development is youth- and family-centered. The TREAT system is designed to meet youth and their families where they are and help take them where they want to go. Historically, care systems assessed youth from an outside-in perspective and then, based on expert opinions, wrote plans for (rather than *with*) them. Unfortunately, one result of this strategy was that the staff owned the goals and the plan. That is, the staff identified the goals, and when the youth did not follow the plan toward the staff-identified goals and was confronted by staff, they could simply, and accurately, abdicate responsibility. After all, it was not their goal or plan to begin with. Another problematic result for goal-setting in this manner was the routine matching of available program services to youth regardless of their individual interests or other practical considerations. So, if the program had a greenhouse, the kids got horticulture as part of their plan. Many youth in juvenile justice systems in various jurisdictions over the years have received certificates in small engine repair or cosmetology without the youth having any identified career interests or ongoing motivations in those areas. Prescribed goals and services, even when offered with the best of intentions, often failed to motivate youth and families to do the hard work of self-reflection, skills-learning and practice, and other challenging self-change tasks.

Even when care systems staff did ask youth for their self-generated goals, they were often quick to dismiss the goal if it was thought to be unrealistic or somehow impractical or unattainable. Staff might ask for a back-up goal which youth accurately translated as a vote of no-confidence—a statement of the expectation for failure. In the TREAT model, staff strive to work with any goal, noncriminal, nonantisocial, or non-self-abusive. Goal-setting can be a challenge with youth involved in juvenile justice care; it is not typically a practiced skill for this population. The youth in juvenile justice care often have a well-documented history of failures in various settings and of giving up in the face of obstacles or negative feedback.

They often learn early in their development not to set goals, not to dream, and when they do, they are told that their dreams are impossible. In the TREAT system, staff recognize that good outcomes can be obtained even if the ultimate goals are not reached. The emphasis is on engaging youth in a motivated process of positive growth and change with less emphasis on the ultimate outcomes. Staff strive to find youth motivation for positive gains: to engage youth in positive change, regardless of an outcome that may not be apparent or even measurable for many years. So, a youth in care who wants to be president of the United States would have to graduate from high school, learn leadership skills, learn negotiation skills, have good interpersonal skills including anger management, deal with substance abuse issues if present, accept feedback, work well with others to solve problems, and learn how to take responsibility. The list of health-promoting steps toward that goal can also go on and on. If youth achieve even a few from the list, they have obviously benefitted regardless of whether or not they ever actually become president.

Thus, a thoughtful analysis of the youth and family's self-identified aspirations and goals, when considered in light of an assessment of their strengths, assets, obstacles, and challenges, illuminates the plan for supports, services, and interventions. If done well, such a plan uses the motivation of the youth to drive their engagement with supports, services, and interventions, leading to healthy growth and development.

An important goal for all youth in care is not just to leave a residential facility, not just to go home, but rather to learn how to live a life: how to self-assess strengths and weaknesses, how to identify obstacles, how to identify supports and resources, how to engage others successfully to find ways to meet their needs, how to learn the process of goal setting, and how to accomplish their goals. In the TREAT model, this process is referred to as effective independence and is considered a crucial life skill. Youth learn the fundamental skill of living life purposefully, setting goals, working toward their attainment, doing what they are capable of on their own, identifying and engaging helpful others when assistance is needed, accepting the help that is offered, assessing their progress and modifying their strategies for achieving goals as needed, and repeating the process as goals are attained or change over time.

Engagement

The third foundational concept is engagement. The creation of community is crucial to the success of the TREAT model. Community is formed among individuals who understand the importance of safety and the impact of trauma on themselves and on others, and who have a developed a repertoire of skills to use in the face of stress and trauma reactivation. They have made a commitment to safety and to support their fellow community members. People are both accountable and responsible for their behavior and are supported, not judged, when they

struggle. Multidisciplinary teams of staff, family members, and each youth comprise a support team whose function is to assist the youth and family in achieving self-identified goals. Each member of the team brings skills and expertise to bear in supporting the advancement of youth goals.

Engagement of others and the creation of healthy and non-abusive relationships provide a healing intervention for those who have been traumatized, but these are often among the most difficult treatment tasks for them to do. Survivors of trauma need to learn that past experiences are not 100% predictable of future experiences and that not all interpersonal interactions are or will be hurtful. Understandably, it can be terrifying to push beyond the fear born of their own experiences and based on chronic and repeated negative outcomes of relationships and interactions with others.

In the TREAT model, teams of providers are developed to create and maintain consistency in relationships. Youth can develop predictable, healthy connections to trained staff who rely on each other to support youth in their day-to-day progress. So, once unit staffing is established, staff do not work on other units, except briefly in emergency situations, but remain consistent for youth in care and their peers. In this way, consistency and predictability can help counteract the posttraumatic expectation and experience of chaos and unpredictability in people and environments.

TREAT Engagement: Training with Youth and Staff Together

Another opportunity for the creation of community among the youth and staff in the program is during training. In the TREAT model, education on trauma and training in skills-building are offered to staff and youth together. This sends a clear and important message, especially around the learning about trauma: This material is so important that we are going to learn it together. Staff and youth learn the didactic material together, staff can model by asking clarifying questions, and each group gets to hear the other's perceptions of the new programs and material, and can discuss how the ideas will be used on their units. It is powerful to engage youth in this process together, as they can both witness and experience how people grow, learn, and challenge themselves in healthy ways. Also, TREAT staff are trained in the components of the overall model. Administrators, maintenance staff, teachers, cooks, nurses, and secretaries are trained and expected to understand and utilize the principles of TREAT in their individual roles in the program and in support of others and the youth who are in care. The expectation is that changes in program philosophy and practice as described here will occur at all levels of the system and to the benefit of all of its members.

When individuals are engaged in healthy relationships and can understand and be sensitive to each other's histories, they can address issues and maintain accountability without judgment. That is, understanding the origin of a behavior, , flipping over every desk in a classroom following a trauma trigger, is help-

ful to frame an adaptive response, such as helping youth ground themselves to counteract a flashback. However, it does not change its impact on others, such as other youth fleeing the classroom, people feeling unsafe, disrupting the learning, and halting the program. The actors are still responsible for their actions and for the outcomes of their actions. They are responsible to people to whom they are connected, so the resolution must include a repair, in addition to any punitive consequences. The repair is needed to address the impact of their actions on the relationships that they need to continue to grow and develop in healthy ways. It may include an apology, a task, such as fixing something that was broken, or some way of making it right to others. When problematic behavior is identified as an obstacle to self-identified goals and an impediment to healthy relationships, the youth can learn to accept responsibility to themselves and to others. This creates empowerment and supports self-regulation as the connections between actions and outcomes are continually identified and made clearer. Staff do not need to invoke facility rules, when the actual issue is that youth are interfering with their own progress toward their own goals. Staff who use this conceptualization can avoid power struggles and conflict with youth.

The obstacles to successful attainment of even simple goals, for example, successfully completing aftercare or probation, for youth involved with juvenile justice can be numerous. Therefore engagement must include as broad a network of supporters for an individual youth as can be identified. TREAT is designed to promote engagement of family resources, community resources, and others whom the youth and family might identify as supportive members of their team. Skills and strategies learned in a residential setting can often be challenging to implement in a community setting and require out-of-agency supports. TREAT teams are using video and audio conferencing technology and in-person meetings wherever possible to engage others in support of the youth in care.

Discussion and Implications

Historical approaches to service delivery to youth in juvenile justice care often used deficit-focused assessments of youth, authoritarian strategies to manage problem behavior that ultimately relied on physical power and force, and behavioral systems that were more geared toward punishing in order to suppress problem behaviors than in developing and reinforcing skillful, positive behaviors. Outcomes were quite limited, and staff found themselves dealing with high levels of violence, poor staff morale, high rates of injuries to youth and staff, and high recidivism rates. Many factors have combined to create a fundamental change in the philosophies and strategies that underlie juvenile justice service delivery. Youth who remain in juvenile justice care following the shrinking of juvenile justice service delivery systems present significant challenges to providers because youth in care often have individual and family challenges, limited internal and external resources, and significant trauma histories.

TREAT is a trauma-responsive model offered as a plan for the delivery of services to youth in juvenile justice care that creates both individual change and cultural change. Modifications to juvenile justice service delivery systems need to be based on the creation and maintenance of a safe environment for the youth in care and the staff who serve them. Using a trauma-informed program component, TREAT is designed to engage all of the members of the service delivery community in the process of establishing and maintaining a safe environment. It is understood that all of the members of the community, youth and staff alike, are potentially impacted by their personal trauma histories, and they are joined in the common goals of being safe and responsible to each other for their shared environment.

When TREAT's foundational concepts are integrated and implemented concurrently, the resulting programs can engage in both procedural and cultural change. Safety in the milieu is supported through the use of clear expectations and consequences, reinforcement of skillful and healthy behaviors, and the relationships among community members. Crucial to the implementation of TREAT is the notion that everyone in the environment is engaged using the same principles, and they are expected to use the same skills to manage their own emotions and behavior. Staff have different roles in working with youth and facilitating program and youth goals, but they are afforded the same supportive, nonjudgmental environment as the youth in their care. TREAT entails systems in the past that maintained safety primarily through external force to become systems that use supportive relationships as the foundation for safe and healthy growth and development.

Historically, and in currently corrections-based juvenile justice programming, emotional dysregulation or behavioral noncompliance is commonly assumed to be the result of delinquency or open defiance. This hypothesis on youth behavior presumes volition on the part of the youth. It also invites a personalized characterization of youth behavior by the staff member, which frequently leads to negative affect or the reflexive use of control-focused strategies to facilitate behavioral compliance. The personalization of conflict is typically evident in both directions of the interaction between youth in care and facility staff. Also inherent in such systems is the use of authoritarian power as a means to attempt to gain behavioral compliance. This combination of factors consistently leads to unnecessarily personalized power struggles between youth and staff, often resulting in and perpetuating escalated emotional and behavioral dysregulation in youth. Too frequently, the end result of this interaction is the use of physical interventions on the part of staff, which have understandably become increasingly intolerable in consideration of the physical and emotional damage that results. When staff understand and can implement, or even consider, a trauma-based explanation for dysregulated emotions or behavior, they have the opportunity to respond to youth in ways that maintain connection and engagement, reestablish safety, and do not lead to the power struggles which have often led to physical conflict.

In the TREAT system, staff are taught to understand the impact of trauma

on development, recognize the indicators of trauma histories in youth, and identify the current emotional and behavioral consequences of trauma experiences in youth. Following such training, a primary hypothesis to explain emotional dysregulation or behavioral noncompliance by youth could posit a link to the youth's trauma history via a more immediate cue or trigger in the environment. While the staff do not ignore the personal responsibility of the youth or abdicate the role of authority in response to youth behavior, the trauma-responsive hypothesis opens several avenues for staff intervention, none of which include the personalized power struggle described previously. Staff who do not presume intentionality do not personalize the problematic interaction. Staff who are able to see the functional goal of trauma-triggered behavioral dysregulation, often to gain safety in a situation which is perceived by the youth as unsafe, can intervene using relationship- and skills-based interventions. Rather than meet the youth head on in a struggle for behavioral control, the staff can join the youth side-by-side and work toward a common objective of emotional and behavioral self-regulation in the service of youth-identified goals.

The TREAT model includes the creation and maintenance of a trauma-informed milieu in conjunction with empirically validated skills-based treatment modalities and an effective behavioral reinforcement system as a means to address emotional and behavioral issues in a juvenile justice residential setting. This combination moves TREAT from a trauma-informed to a trauma-responsive program.

The foundational principles of the TREAT model, which includes safety, skills, and engagement, are interdependent. Safety cannot be achieved without the use of skills in the context of interpersonal relationships of engagement. Skills cannot be learned without the experience of safety and the willingness to try new skills, and without the engaged support by teaching and reinforcement of others. Engagement between individuals cannot occur if they do not feel safe and do not have the skills to interact without hurting each other.

Conclusion

TREAT provides a model for programmatic and cultural change in juvenile justice residential programs. It is designed and implemented in a way that is sensitive to the trauma of everyone in the environment, recognizes that safety is the foundation of treatment, and benefits both staff and youth. The foundational concepts and program components of the TREAT model may also be applied to outpatient or community-based programs to create systems which are strength-focused, safe, and trauma-responsive.

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THE HOSPITABLE COMMUNITY: A TRAUMA-SENSITIVE ENVIRONMENT FOR CHILDREN AND YOUTH

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In his epic tale, the *Odyssey*, Homer drives the hero Odysseus from Troy to one inhospitable beach after another in his ten-year quest to return home to Ithaca (Homer, 1995). Over the course of his journey, fickle deities strip this wealthy, privileged, and wise warrior of his resources, relationships, and even hope. Odysseus is separated from his royal father, noble wife, and promising son. Ultimately, he is an outsider, naked and weak as a child; Odysseus literally becomes a "nobody" (Homer, 1995, 9:366). He stays in many places, yet in the best of them he longs for family and home. Throughout the narrative, Homer marks the quality of character of each person Odysseus and his son Telemachus encounter by the quality of hospitality that they extend to these weary travelers (Arterbury, 2005, p. 32; Bolchazy, 1977, p. 2; Louden, 2011, p. 32). Both Siren and Cyclops are dangerous because their power toward outsiders serves their hunger instead of that of their guests. In contrast, the virtuous Nestor and Menelaus open their homes, provide for and protect their guests, and, to the fullest extent of their considerable power, send them toward a hopeful future.

In a way that is unfortunately similar to the path of Odysseus, some at-risk children drift from house to house wondering if they will ever be able to find their way home. Though most placements in foster and residential care are successful, some result in one disrupted placement after another (Rosenthal, 2011; Sinclair, Wilson, & Gibbs, 2005, p. 136). Perpetual outsider status deepens the struggle of children coping with trauma (Herman, 1992, p. 52). At the mercy of well-intentioned forces that they sometimes see as fickle, these young people find themselves separated from family and cast as outsiders upon the doorsteps of a sequence of strangers, whether in foster care or residential child care. Some hosts are hospitable; others, at least to these young wanderers, appear hostile to their culture, family, or even their person (Payne, Devol, & Smith, 2001, pp. 39–48). This failure of hospitality frequently results in another disrupted placement, which can hinder the young person's progress toward healing from trauma, a clear identity, or a sustainable future (Sinclair et al., 2005, p. 138). It can also stimulate problem behavior not previously present (Strijker, Knorth, & Knot-Dickscheit, 2008). However, where homes offer a virtuous quality of welcome, youth can find healing and hope.

The outsider status of these children provides a clue as to the best strategy to help them. Hospitality, in the ancient Mediterranean sense of the word, is a virtue and practice that welcomes, protects, cares for, and relaunches the troubled outsider. Hospitality as a cross-cultural tool has entered the conversation in many contemporary fields of study: social work (e.g., Sackreiter & Armstrong, 2010; Sirriyeh,

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2013), education (Langmann, 2010; McAvoy, 1998), philosophy (Derrida & Dufourmantelle, 2000; Dikeç, Clark, & Barnett, 2009), and theology (Russell, 2009). Kouri suggests that the concept of hospitality is the way forward in youth care (Kouri, 2012). The practice of hospitality also has prominent exemplars among diverse faith perspectives: Buddhist (De Béthune, 2007), Christian (Arterbury, 2005), Muslim (Akpinar, 2007; Shryock, 2009), Jewish (J. M. Cohen, 2006), and polytheist (Bolchazy, 1977). From the viewpoint of those who do not believe in a god, Derrida equates hospitality with ethical behavior (Derrida, 2001).

Based on the ancient practice of hospitality, this work describes a trauma-sensitive environment for at-risk youth living in out-of-home placements. This methodology was designed and tested in a qualitative research project conducted at a residential childcare facility caring for at-risk boys (Bruner, 2010). Hospitable communities well serve the needs of traumatized children and youth, whether they take the shape of foster families or residential child care facilities. The objective is to help these nontraditional care giving families find balance in how they care for troubled youth. How ought such families open their homes to children who often have very different boundaries? How might families remain vulnerable enough to hear the traumatic narratives of these youth and yet maintain a safe space for others? How can adults avoid dwelling on the difficult truths of these young lives and work with these youth to find hope instead? This study seeks a trauma-sensitive balance of these factors.

Definitions

In this work the term *community* will refer to the collection of persons providing care to and sharing space with children, whether family, residential child care team, or treatment team. By its practice of hospitality, the community shapes the welcome that youth feel in its midst. We will use the definition of *hospitality* given by Henri Nouwen:

> Hospitality, therefore, means primarily the creation of a free space where the stranger can enter and become a friend instead of an enemy. Hospitality is not to change people, but to offer them space where change can take place. It is not to bring men and women over to our side, but to offer freedom not disturbed by dividing lines. It is not to lead our neighbor into a corner where there are no alternatives left, but to open a wide spectrum of options for choice and commitment (1975, pp. 71–72).

Hospitality is one of several virtues, with *virtue* meaning "persistent excellence in being for the good" (Adams, 2006, p. 11). Virtue is not merely doing the right thing with the right motive; it is doing something repeatedly and consistently enough to rise to a level of excellence. A vice is not a momentary lapse, but the continued practice of that which is not good. An *ideology* is a framework that

values specific perspectives and virtues while deprecating certain vices. However, many different ideologies might value a specific virtue like hospitality or respect. Such virtues can empower cross-cultural dialogue. *Character* is the sum total of the virtues and vices of an individual or a community. Virtuous individuals and communities, knowingly or not, read and interpret their context using a hermeneutic that coheres with their ideology. *Hermeneutics* is the individual and communal interpretation of texts and experience, simultaneously art and science (Gerkin, 1984, pp. 19–20). The term *child* will serve for both children and adolescents in this study.

An Overview of Trauma Treatment

Since Judith Herman's foundational work in trauma (1992), therapists have sought to identify effective treatments to help the victims of trauma move forward. Initially perceived to be an adult diagnosis, researchers eventually established the debilitating effects of trauma in the lives of children and began to develop evidence based approaches for treatment specifically for children and adolescents (J. A. Cohen, Mannarino, & Deblinger, 2006). Most of these approaches follow a course of treatment that is a variation on the theme established by Herman; they seek to: establish safety for all present; remember and mourn the trauma; and finally, reconnect the victim with life on the far side of trauma (1992, p. 155). Most trauma to children occurs within a relationship, yet it is within relationships—with a therapist, family, or community—that healing from trauma must take place (Kinsler, Courtois, & Frankel, 2009). For healing to begin, most researchers agree that the prime virtue of the environment surrounding the child must be safety (Ford & Cloitre, 2009, p. 67). The child must perceive the therapist to be a safe and trustworthy person, yet the child must perceive their community to be safe as well or progress on any treatment plan will be halting. Safety plans can ensure that the child feels safe throughout the course of treatment; the child also ought to acquire personal safety skills as they prepare to leave therapy (J. A. Cohen et al., 2006, pp. 157–165).

Other virtues besides safety are necessary for a therapeutic relationship and community. For example: "Healing of complex and chronic trauma . . . occurs in safe, dependable, kind, and bounded relationships" (Kinsler et al., 2009, p. 183). Since most researchers do not prescribe communal virtues for a treatment milieu, how might such a virtue list be constructed? One way is in the identification of virtues underlying treatment principles. Principles define practices that, when done persistently and with excellence become virtues. Ford and Cloitre prescribe a useful set of principles for psychotherapy with traumatized children: (a) establish safety; (b) open relational bridges; (c) design diagnosis and treatment relationally; (d) focus on strengths (not deficits); (e) build self-competency; (f) choose where, when, and how to discuss traumatic memories; and (g) avoid or cope with relational discontinuity (Ford & Cloitre, 2009). Since the child's community, or treatment milieu, should cohere with the therapeutic relationship, that reality would require the community to exhibit virtues consistent with such practices: (a) safe;

(b) open, to new or deeper relationships; (c) flexible, especially to the needs of the child; (d) truthful and hopeful; (e) equipping; (f) vulnerable, in the healthy sense of the word; and (g) persistent. These virtues are the virtues of a hospitable community.

Out-of Home Placements and the Broader Moves of Hospitality

Ancient Mediterranean hospitality serves as both a metaphor and practice positively framing the care of children in out-of-home placements. In ancient hospitality there were three broader moves to the hospitable event: the welcoming of the unknown stranger, the dwelling together in conversation around a table, and the providential sending forth to the next place on the traveler's journey (Bruner, 2010). In brief, the three movements of ancient hospitality are: welcome, abiding, and sending forth. The three stages of hospitality resonate with the three stages of trauma recovery:

1. establishing safety for all present,
2. coping with remembering and mourning the trauma, and
3. reconnecting youth with life on the far side of trauma (Herman, 1992, p. 155).

In ancient hospitality, the welcome was key. An outsider would enter a community, find greeting from a host, who would greet the guest, bring them into his or her home, see to his or her needs, and—only after the outsider was bathed, clothed, and well-fed—inquire into the outsider's identity and background (Homer, 1995, 1.120–210; 3.29–100; 4.20–182; 5.85–95; 6.13–320; 7.140–315; 14.30–120). Depending upon his or her needs, guests would remain under the roof of the host, sharing shelter, resources, and their personal narrative until the guest was ready to move on. Then, to empower his or her guest's hope of making their destination, the host would equip the guest with resources and often send an escort to take his or her guest onward (Homer, 1995, 3.346–498; 8.25–45; 13.47–92). These practices clearly connect with out-of-home care.

Yet those families who willingly let any stranger sit at their table soon discover that hospitality is more complex than sharing a meal. Both ancient and contemporary understandings of hospitality involve a host encountering a guest. However, virtuous hospitality is the encounter of "one" with the "other," with the differences of culture, context, perspective, language, and ideology to be bridged. Virtuous hospitality is a hospitality of ideas. The religious faith or deep-seated morality that calls many couples to become care givers can either fund hospitality or become the source of identity and boundary issues that can complicate or terminate foster placements. Rules-based systems of checks on such xenophobic behavior are not helpful because of the infinite number of possible situations out-of-home placements can generate (Rose, 1999, pp. 181–183). A simpler and more flexible frame-

work, a hermeneutic of situations might be easier to remember and more helpful in practice.

Hospitality and Hermeneutics

Policies and procedures are important in establishing a trauma-sensitive environment; yet each day brings new situations to caregivers. It is infeasible for agencies to constantly update manuals to deal with these new realities (Bloom, 1997, p. 122). Even if a community were able to attempt the construction and maintenance of such a document, its size would soon exceed what a human could readily recall or enact. What caregivers need instead is an agreed-upon hermeneutic that allows them to read their situation and respond appropriately (Gerkin, 1984). Russell clearly defined a hermeneutic of hospitality in *Just Hospitality*: "Our hermeneutic of hospitality can (1) pay attention to the *power quotient* involved in what is said and who is saying it, (2) give priority to the *perspective of the outsider*, and (3) rejoice in *God's unfolding promise*" (Russell, 2009, p. 43). Bruner has subsequently broadened and balanced Russell's categories and defended their use in a child care context (Bruner, 2010). In Bruner's hermeneutic, a community must read its context and frame its actions with a cluster of virtues that make hospitality virtuous, effective, and just: safety, vulnerability, maintenance of identity, openness, truthfulness, and hopefulness. This virtue list is very similar to the list of virtues describing a community appropriate for traumatized youth (see above).

When first considering vices and virtues in any hermeneutic, it might seem that they exist in binary pairs: each virtue has its opposing vice. For example, courage and cowardice stand in opposition. Aristotle's solution is more complex; he asserts the existence of the virtuous mean (Nicomachean Ethics, II, 8 & 9). Cowardice may be the vice of inability to function despite the presence of fear, while courage is the virtue of being able to function despite the presence of fear, yet there is a third point. Rashness is the vice that results when one acts in the face of a risk that should not be ignored (see figure 1 – Aristotle's Virtuous Mean).

For example, if someone were to dash out in front of a moving car in order to pull a child out of the way, most observers would count that as courage. If the same person ran out in front of a car to retrieve a basketball, most would mark that as rashness.

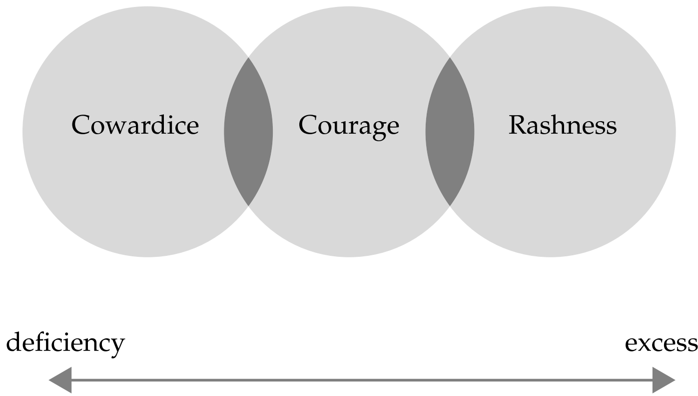

Figure 1: Aristotle's Virtuous Mean

Adams suggests, using courage as an example, that virtues are contextual and modular. The kinds of courage that constitute virtue in intellectual, physical, emotional, and social domains are categorically different and depend upon those specific contexts (Adams, 2006, pp. 179–184). The courage required to rescue the wounded from the battlefield is different than the courage required to care for the traumatized at the dinner table. The differences in these types of courage reveal the modularity of virtue; there are modules of virtue that form the larger virtue (Adams, 2006, pp. 125–130). I assert that risking vulnerability is a module of courage, a definite move away from cowardice. Simultaneously, maintaining some degree of safety is the module of virtue empowering courage to avoid rashness. Safety and vulnerability are virtues constituting modules of the virtue of courage. These modular virtues must be kept in tension with one another for courage to be virtuous. That tension is not static, but constantly changes with variations in the context, circumstances, participants, and resources.

A Hermeneutic of Hospitality

In a similar way, Bruner's hermeneutic has three lenses, each lens holding two hospitable virtues in tension (see Figure 2: Tensive Hospitable Virtues). Use of these lenses allows the individual or the community to read their situation and evaluate whether the traumatized guest is experiencing just hospitality. If not, then the lenses help identify what the problematic issues might be. An examination of each of the three lenses follows.

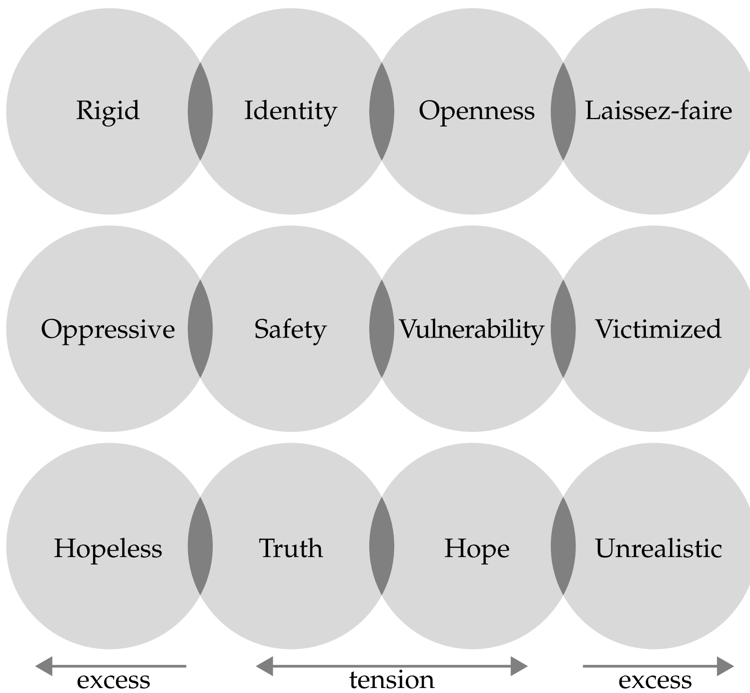

Figure 2: Tensive Hospitable Virtues

Openness and identity. There must be an understanding of the balance between *openness* and the identity in the relationship between the community and outsider (Russell's "perspective of the outsider"). In this tension, family members and outsiders share access, culture, voice, and relationship. It is obvious that a community must be open to receive a child in an out-of-home placement; no less important is the necessity of the child to be open, despite differences, to that placement. Lartey reminds those engaged in intercultural work that all humans are in some aspects "like all others," "like some others," and "like no other" (Lartey, 2003). Although caretakers cannot change their culture or core identity, they can be open enough to provide a "symphony of support" for outsider children (J. A. Cohen et al., 2006, pp. 40–41). Not only must the host community be sensitive to the culture of the traumatized youth in its midst, it must be aware that trauma may reveal itself in different culturally-normed ways because of the young person's native culture. At the same time, the child must choose to be open and accommodating to a new environment with different boundaries. Neither host nor guest must be so "open" to the other, though, that he or she loses his or her identity or personal boundaries. Equating the person without boundar-

ies to a person without identity, a nobody, Nouwen asserts, "No real dialogue is possible between somebody and a nobody" (Nouwen, 1975, p. 99). However, host and guest must realize that the very natures of hospitality and relationship are such that presence of the "other" in hospitality will change both.

Safety and vulnerability. The community must measure the tension between *safety* and *vulnerability* in the situation (the"power quotient"for Russell). Human beings are essentially dangerous. The experience of most humans warns them that those proven dangerous often repeat dangerous behaviors; in the eyes of some traumatized youth, almost anyone is potentially dangerous (Kinsler et al., 2009, pp. 184–185). Therefore, the radical openness to reconciliation and hospitality described above risks the repetition of violence from either the incorrigible perpetrator or the fearful and defensive victim. Somehow the community and the child must negotiate a balance of safety and vulnerability. Safety is a condition and virtue more broadly descriptive of the human need to avoid suffering, whenever possible, for self or another. Safety is not just the avoidance of pain caused by the abuse of power; it is also security against injury from unintentional, neglectful, or self-inflicted dangers, and providence for those resources and relationships that are life-giving. Vulnerability is more than dropping one's defenses; it is not weakness (Brown, 2012, pp. 32–56). It is the willingness to hear, see, receive, sympathize, and possibly even suffer with or for another.

One way to balance safety and vulnerability is through an ongoing conversation about reasonable expectations; at times this might take the form of a covenant (Bruner, 2010). The objective is for the hospitable family and guest to safely share resources, including possessions, space, and power. Care givers, though, should not be surprised when a child well into the healing process chooses to test, sometimes severely, the balance of safety and vulnerability (Perry & Szalavitz, 2006). Rose gives a helpful metaphor describing the phenomenon:

> An individual's refusal to acknowledge love or nourishment may mask a state of unconscious terror. As his or her frostbitten emotions begin to unfreeze in the consistent warmth of the therapeutic relationship, pain rather than absence of feeling is bound to make itself felt. The response may well be an increase in extremely destructive behavior. The journey from a frozen childhood and adolescence to a creative and loving adulthood, will inevitably be a passage of fear and grief. Thus the staff, with their complementary therapeutic task, cannot avoid daunting emotions either (Rose, 1999, p. 180).

Virtuous hospitality copes with this pain, deflects and corrects the behavior, and gradually equips the young guest with the social and psychological resources needed for the journey ahead.

Truthfulness and hopefulness. Communities must maintain the tension between *truthfulness* and *hopefulness* (in Russell's hermeneutic, "unfolding promise"). Gradually bringing truth and hopefulness into balance turns the attention of the traumatized youth from past wounds to an improved level of functioning in the present and the possibility of personal transformation in the future. The persistent problem is discovering and dealing with the traumatic truth without being defined or limited by it. Helping young people build successful lives is frequently much more about helping them use their strengths so as to minimize their weaknesses and create an identity not defined by their dysfunction (Peterson & Seligman, 2004). After understanding and acknowledging that the trauma is not their fault, the child can look hopefully toward a future where they are self-regulating (Ford & Cloitre, 2009) and empowered to secure safety for themselves (Cohen et al., 2006).

Shifting Tensions in Hospitality

It should be noted that the tension point may be at very different places for the community and a particular individual. The parent of a care giving family may feel no threat from the acting-out behavior of a traumatized youth struggling with the healing process. However, there may be younger children (biological, foster, or residential placements) in that community for whom such behavior may represent a danger of some extent. Appropriate safety plans for all involved may allow the hospitable situation to continue uninterrupted even though strained. Kumpfer and Summerhays give this advice:

> No child today is beyond risk; no child is, or could be, completely protected. Exposure to moderate stressors, challenges, and risks can help children develop effective coping responses and resilience. Wise parents naturally titrate a child's temperament, capabilities, and resilience with levels and types of stressors before allowing or encouraging new challenges (Kumpfer & Summerhays, 2006, p. 152).

Children are not the only vulnerable humans; if, for example, the type of trauma experienced by the child is too similar to the trauma experience of one of the adults present, then that placement may or may not be optimal for guest or host.

The completed hermeneutic of hospitality consists of three sets of tensive dyadic virtues: security and vulnerability, identity and openness, and truth and hope. Although all of these virtues have value throughout any phase of hospitality, each of these sets of tensive virtues is more prominent within one of the three larger moves of hospitality: welcome, staying, and sending. The virtues of identity and openness shape the quality of welcome a community shows an outsider and may even determine which outsider might gain entry. When the community properly holds identity and openness in tension, even a person who might be considered an

adversary of the community can find welcome and voice within hospitality without endangering the identity of the community. As host and guest dwell together in the hospitable event, the virtues of safety and vulnerability rise to prominence. When the community properly shares resources with its guests, most prominently voice and power, then the balance between safety and vulnerability allows healthy relationships to form and empowers the lives of both host and guest to prosper. Finally, in order for the sending forth of the guest to bring joy and sustainable life for host and guest, somehow he or she must balance truth and hope.

Comparisons to Other Models

The concept of hospitable community empowers the ongoing quality improvement of a community of care, provides a common language for dialogue and decision making, and reduces stress for most care givers (Bruner, 2010). The hospitable community constitutes an environment similar to other successful treatment milieus. The Sanctuary Model®, for example, seeks to establish a safe environment for both client and professional (Abramovitz & Bloom, 2003). Sandra Bloom created this model for use with adult trauma victims (Bloom, 1997), but others have now adapted it for use in youth residential programs (Rivard et al., 2004). They use this nonlinear model to pursue safety, emotional management, loss work, and future for both clients and the treatment community, thus, the mnemonic: SELF (Foderaro & Ryan, 2000; McCorkle, 2007). Like the Sanctuary Model, the hospitable community pursues the same tasks in the three moves of hospitality. The community of hospitality welcomes others by balancing the *safety* found in Sanctuary's SELF with *vulnerability*, provides abiding space for emotional management and grief in a space balanced in *openness* and *identity*, and sends forth children, aware of the *truth* of their past, moving on to a *hopeful* future.

The concept of hospitable community also provides Haigh's five ingredients for a treatment community, which Haigh places in a "developmental" order: attachment, containment, communication, involvement, and agency (Haigh, 1999). In a hospitable community, welcome involves the first element; abiding facilitates the second, third, and fourth; and agency is prominent in sending forth.

Conclusion

The aim of this study has been to present an overview of concept of hospitality for constructing a healthy milieu for the care of children who have experienced trauma. The actual practice of hospitality in such a context requires complete coherence and total community commitment, including that of the leadership of the community and every person living within it. A community must commit to and engage in considerable dialogue and preparation to implement the concept; that process is more likely to be successful when it begins with the basic concepts. Faith communities may choose to construct their practices based on the narratives of hospitality particular to their faith; as mentioned above, most faith communities have

exemplars and stories to access.

The practice of hospitality empowers caregivers to share an environment with traumatized youth in which he or she can find a safe welcome, remain to recover from his or her trauma, then experience a clean launch into a resilient life. The use of a hermeneutic of hospitality empowers the community to create a hospitable environment, share realistic expectations of what life together might be like, reduce stress for host and guest, and prevent untimely exits and unnecessary additional placements. Hospitality provides an important and empowering resting place for young weary travelers on their odyssey to safely return home and finally rejoin family.

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TRAUMA AND RELATIONAL CARE: INTEGRATING AN AWARENESS OF TRAUMA INTO THE CHARACTERISTICS OF RELATIONAL CHILD AND YOUTH CARE

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Abstract: Healing—the restorative process of becoming healthy and whole—is a central element in recovery from trauma. The integration of trauma-informed care into relational practice supports this healing process. The characteristics of relational child and youth care have been defined (Garfat & Fulcher, 2012) and organized into a framework (Freeman & Garfat, 2014). The impact of trauma and an example of relational trauma in early childhood are explained, and select characteristics are identified and described in the context of trauma-informed practice.

Key words: relational care, children and youth, trauma

Healing is the restorative process of becoming healthy and whole, and is a central element in recovery from exposure to childhood trauma. It is a natural outcome of quality relational child and youth care. When a human life begins to be restored, individuals regain their own dignity, value, and original glory. This process is facilitated through relationships. A relational approach to recovery from trauma acknowledges that "relationships between careers [sic] and young people are the primary means through which opportunities for healing, development, and flourishing are provided" (Smith, Fulcher, & Doran, 2013, p. 42). Relational practice must be responsive to the impact of trauma in order to best support the healing process for young people and their families.

Moving Beyond Labels

Too many systems and people are preoccupied with labeling and diagnosing the problems we experience in life. There are numerous categories related to trauma, including complex trauma, developmental trauma, posttraumatic stress, and a range of trauma related disorders. There has also been, over the past decade, an emphasis on becoming trauma-informed in our systems of care. While knowledge and skill in connecting with and supporting young people affected by trauma are critical in our work, the emphasis on trauma-informed practice often seems more connected to marketing a model or system than it is to personalized, relational care.

The awareness people have of the world is largely filtered through how they have learned to see and interpret their experiences and the experiences of others. Consider how this impacts the way in which one understands a young person's experience of trauma:

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> If their doctors focus on their mood swings, they will be identified as bipolar and prescribed lithium or valproate. If the professionals are most impressed with their despair, they will be told they are suffering from major depression and given antidepressants. If the doctors focus on their restlessness and lack of attention, they may be categorized as ADHD and treated with Ritalin or other stimulants. And if [one] happens to take a trauma history, and the [young person] actually volunteers the relevant information, he or she might receive the diagnosis of PTSD. None of these diagnoses will be completely off the mark, and none of them will begin to meaningfully describe who these [young people] are and what they suffer from (van der Kolk, 2014).

The task of child and youth care practitioners extends beyond labeling young people and involves engaging them in a meaningful way. This requires both an understanding of trauma as well as an understanding of the core characteristics of relational care.

The Impact of Trauma

Traumatic experiences can occur early in life, be complex (e.g., multiple events, occurring over time, interpersonal), and they are known to have adverse impact over a lifespan (Anda et al, 2006). Trauma can be the result of abuse, neglect, or witnessing violence in the home as well as related to loss, poverty, and other life experiences.

Childhood trauma can impact the whole young person, especially the way an individual thinks, feels, and interprets the world. This can become problematic when a young person is exposed to "danger that is unpredictable and uncontrollable because the child's body must allocate resources that are normally dedicated to growth and development instead to survival" (Cook, Blaustein, Spinazzola, & van der Kolk, 2003, p. 8).

The impact of trauma has both immediate and long term outcomes. This can result in young people having a "distrust of other people, inhibition of curiosity, distrust of their own senses, and the tendency to find everything unreal" (Bowlby, 2008, p. 103). According to the National Collaborative on Adversity and Resilience, such adversity in childhood:

> [It] changes the way children learn, play, and grow, [and] biomedical research has shown how early trauma can last a lifetime: It leaves tracks in the brain, floods the body with stress hormones, hikes the risk of engaging in unhealthy behaviors and boosts our vulnerability to heart disease, depression, diabetes and other physical and mental health problems. [Yet] emerging neuroscience has also affirmed some good news . . . If the human brain can be hurt, it can also be healed (2013, p. 6).

When a young person is preoccupied with survival, there is less attention and energy available for normal developmental tasks. The real problem of trauma is the resulting isolation and self-blame that occurs. Relational child and youth care is less concerned with treating the trauma and more concerned with restoring the young person to community and their sense of value. If relationships can be hurt, they can also be healed.

So a key question for the child and youth care practitioner becomes: How can I best support this healing and restorative process for the youth I serve? The following case example highlights this impact during important developmental stages and is followed by a discussion on the characteristics of relational care that support restoration and healing from such traumatic life experiences.

Kids in Cages: A Case Example

Along with her older sister, a young child entered the child welfare system as a result of significant neglect and abuse. Being adopted from the foster care system seemed to offer hope, yet what was to come was more damaging than the experiences of the past. She would soon find herself locked in a cage in her adoptive home in a failed attempt at controlling her behavior.

The school-age girl and her sister were placed in a home with two other children who had also been removed from abusive conditions. Their adoptive mother operated a day care center and had another dozen or so children attending each day. While the children in day care played in the house and outside on the lawn, the four adopted children were kept in the basement, with the two girls locked in cages nearly around the clock.

One of the workers in the day care center explained that she never saw the foster care mother "read to the youngest, never cuddled with her, [and] never kissed her" (Welsh, 2007a). Yet, as vital as reading and physical touch is to child development, this was only the surface of her maltreatment.

In their cages they were fed a diet primarily of peanut butter sandwiches and were given a bucket for toileting. The youngest had "only two sets of clothes, which frequently reeked of urine [and her] boots didn't even fit, being too big" (Welsh, 2007a). Her only experience outside of the basement was when "she was taken outside in the yard to receive an outdoor shower . . . while dressed in her clothes, and was not given a fresh set of clothes to replace her wet ones afterwards" (Welsh, 2007a).

The two girls' older adoptive sister was given preferential treatment. She was, for example, allowed to roam the house and could eat what and when she wanted. Investigators found further abuses: photographs and paintings of her in sexually provocative poses and discovered she was medicated to suppress the onset of puberty.

The social workers who investigated their living conditions described it as cruel and torturous (Welsh, 2007b). Along with the two younger girls being locked in-

side cages, receiving insufficient nutrition, and subjected to the cold and the smell of urine and feces, they were sometimes punished with cold showers in the early morning and having to write apologetic letters describing their own faults and blame. The letters, if not deemed long enough, would result in having even what little privileges they had taken from them.

During the resulting criminal trial, the adoptive mother explained that the girls had tried to manipulate her, and she was forced to lock them up because they had "a syndrome common to some foster children who experience serious difficulties forming emotional bonds [and] because the kids have such deep emotional problems" (Welsh, 2007a). Even though the children received funds from the state through the adoption support system (and at a higher rate than typical payments due to their past emotional trauma), none of the funds were used for counseling, clothes, or other basic needs. In the end, the mother pleaded guilty and received a ten year suspended sentence, serving one year in county jail and the remainder of the sentence on probation.

The girls rescued from this situation of neglect and abuse displayed violent and perplexing behaviors. The approach the parent—and the system—had adopted to caring for them was completely lacking of an understanding of trauma and any concept of engaging them through a caring, relational approach.

After the youngest's removal from the adoptive home, she was placed in a local emergency shelter for abused and neglected children. It was both confusing and comforting for her as she met the adults and other young people in her new environment. During one of her first meetings with her therapist at the shelter, she entered the room crawling from the washroom to the office on the carpeted floor. Her therapist had offered a chair but her only outward acknowledgement was to make motions and sounds like a cat. Her behavior was both confusing and challenging as she seemed to deflect any attempt at connecting with her care providers.

The traumatic experience this girl lived through taught her that it is not safe to trust or depend on others. She, and others from similar experiences, find little perception of safety and tend to develop a negative sense of their own worth. These circumstances make it difficult for such traumatized children to relate with others in the everyday world as they grow and develop. Because of their disrupted experience of the joy of childhood, they are "missing elements of their lives that are vital to optimal development, and these elements often start with broken relationships" (Baker & White-McMahon, 2011, p. 14). It is understandable that traumatized children might work hard to avoid making close connections with others. They may think it is the only way to avoid danger.

Eight months after the girl was removed from her adoptive home and crawled into her therapist's office, she was observed entering a classroom, talking and laughing with peers. She smiled and waved as she entered the room, seemingly on the journey to restoration. She began to experience at least some joy and hope in her daily life. What happened in eight months that promoted such change? The

next section explores some key characteristics of relational care that contributed to her restoration.

Healing in the Everyday: Anchor Characteristics of Relational Care

What should everyday life events begin to look like for this young girl? For this young girl, mealtimes were challenging because she wanted to eat off of the floor. Bathing was unusual and awkward because she had become accustomed to being hosed off in the yard. The typical routines of waking and sleeping and rhythms of daily life had to be reestablished.

How can a child and youth care practitioner use these moments in daily living as opportunities for nurturing growth and development, especially in ways that support relationally reparative experiences? Treatment and behavioral approaches may be helpful, and at times necessary, but the deepest needs for such an individual is relational care that repairs or restores traumatized children. According to Baker and White-McManhon, "Repair [does not mean] a problem that must be completely solved . . . Rather, repair simply means to bring the youth to a [stable and healthy] state that allows for more adaptive functioning and the opportunity to achieve his or her greatest potential" (2011, p. 93). These reparative experiences occur in everyday life, in moments and situations where the child care practitioner in the role of a caring adult is best positioned to be of influence and support.

The following characteristics of relational child and youth care (see Figure 1) have been defined (Garfat & Fulcher, 2012) and organized into a framework (Freeman & Garfat, 2014). The characteristics and framework are straightforward, yet profound enough to ground practitioners in an approach for the length of their career. The focus of this article is the application of the anchor characteristics—love, meaning making, and connection and engagement—and their relevance in facilitating the process of healing from relational trauma.

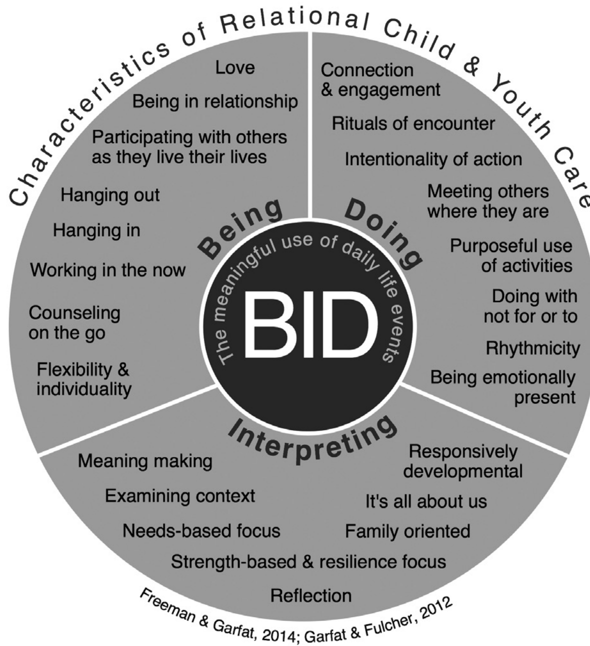

Figure 1: Characteristics of relational child and youth care

Love As a Way of Being

Love is the first characteristic related to our way of being with others (Freeman & Garfat, 2013). Work with young people affected by trauma must come primarily from a place of love. It has a role in both internal motivation and external experience with young people. According to Smith, Fulcher, and Doran, "Love and affection are essential but are often lacking in the lives of children in care, and . . . this has a significant impact on their emotional well-being and, for some, a lasting impact on their future prospects" (2013, p. 43). Love gives traumatized children the experience of someone they can feel safe with, someone who makes them feel special.

Loving young persons struggling with the impact of trauma is not easy or simplistic. The barriers and conflicting feelings in both young persons and practitioners stem from the children's background:

> Repeated experiences of rejection, betrayal, and abuse [which have led to] feeling they are bad, worthless, or not worthy of being loved. This combined with poor developmental competencies and subsequent feelings of ineptitude lead to self-blame and guilt. Negative self—and other—attributions and expectations further exacerbate the…tendency towards hy-

> pervigilance and [disrupted] information processing. Responses to both neutral and traumatic stimuli tend to be confused and disorganized, leading to further self-perceptions of helplessness (Gregorowski & Seedat, 2013, p. 107).

When a young person is scared and struggling with the impact of trauma, love may be the last thing they are able to embrace while at the same time be their greatest need.

Various constructs summarizing human needs have included love. Maslow (1943) labeled it "love and belonging" and placed it in his hierarchy between safety and esteem needs. Glasser (1999) called it by the same name and included it directly after survival needs in his more linear and overlapping categories. Brendtro, Brokenleg, and Van Bockern (2001) integrated it in their more circular model, especially in the concepts of belonging and generosity. As an identified basic need in the human experience, love must have a place in the care of young people.

Some practice settings seem to operate with the idea that love is beyond the scope of relational care. This may come from a place of fear of attachment on the part of the adults or sometimes from a fear of accusation of abuse or poor boundaries. Practitioners must remember that "most young children need a lot more physical affection and admiration than they get, even in a normal family [and while they] must be protected from unwelcomed attention [it can not be] at the cost of denying them one of their deepest needs" (Keith-Lucas, 1993, pp. 1–2).

Keith-Lucas described in a classic article on children and love that one young girl, with similar experiences to the one described above, asked him if he really liked being kind to her: "I could see Emma being told as part of her therapy that the staff loved her but doubting if they really meant it. Words often don't mean much to a child, when actions and body language do" (Keith-Lucas, 1993, p. 3). It is important, that when "one really does love a child, not merely apply love as a [technique or bandage]" (Keith-Lucas, 1993, p. 3).

Love underlies quality care. Child and youth care workers cannot be in this work, at least in a lasting and meaningful way, without a sense of love for others. Love is what keeps one patient and kind. So there is a sense that when practitioners begin to lose their patience or find themselves with unkind thoughts and words, it is love to which they may need to return. Love is what keeps them seeing the potential in others and expecting the best from them. It is what keeps them hanging in with young persons when things get difficult (Garfat & Fulcher, 2012). Love is also what drives them to celebrate the accomplishments of others regardless of who gets the credit.

Making Meaning From Our Experiences

The second characteristic is related to a way of interpreting experiences within in the relational exchange. This is meaning making, which has been defined as "the process young persons go through in making sense of their experiences" (Garfat & Fulcher, 2012, p. 18). Its aim is to guide us in increasing the sense of safety and self-awareness the young persons (and practitioners) have in their experiences.

Experiences of trauma—especially those which occur in early childhood—impact the way persons make meaning out of their other experiences, shaping their worldview and how they understand and interact with others around them. They may come to believe that the world is unsafe. They may internalize feelings and thoughts that they are unimportant or of no value in the world.

Similarly, the adults in young persons' lives are constantly interpreting, even if unconsciously, and looking to make sense out of a children's actions. Without an awareness of trauma and focus on supporting their growth, this interpretation may result in actions that hinder rather than help young persons. Work with young people can become "overly focused on behavior management or even controlling children's behavior . . . [while] effective workers interpret [such] behavior and respond sensitively, rather than immediately trying to impose external controls" (Anglin, 2014, p. 54).

The context behind a behavior might range from grief, fear, anxiety, despair, or hopelessness. It is the challenge and responsibility of practitioners to recognize and respond to the need behind the behavior. They must interpret and reinterpret what they see and help the young persons begin to interpret and reinterpret their experience. How they explain and understand what young persons have or are currently experiencing in the moment directly impacts the validity and effectiveness of their response.

> It is important that [practitioners] adopt the language of collaboration and do not see themselves as agents of control. A trauma-informed mindset assumes that [all behavior] is a result of unmet needs . . . [and that if a young person is] not doing well, there is a reason related to how well they are able to think about and process their immediate circumstances (American Association of Children's Residential Centers, 2014, p. 101).

Interpretation is central to all experience. It occurs whether people are aware of it or not, and pausing to reflect and reinterpret is the first step toward improving the quality of care for young people.

Connection and Engagement as an End, Not a Means

The third characteristic is related to the ways in which child and youth care workers take action in their care: connection and engagement (Freeman & Garfat, 2013). They can be with others and interpret the meaning of their relational exchange, but if there is no action, there is no caring taking place.

> Individuals who have few positive relational interactions—a child without a healthy family [or] clan—during or after trauma have a much more difficult time decreasing the trauma-induced activation of the stress response systems . . . [yet it is] healthy relational interactions with safe and familiar individuals [which] buffer and heal trauma-related problems (Ludy-Dobson & Perry, 2010).

The most important thing young persons affected by trauma need is to connect with another. The aim of this action or way of doing is to support young persons in their process of restoration.

Meaningful connection and engagement are difficult to achieve, if at all, in rigidly prescribed roles that emphasize physical and emotional distancing from young persons. It is only when practitioners involve their "personal selves into caring relationships in a professional context that . . . [they] can enter into such relationships with appropriate authenticity and spontaneity" (Smith, Fulcher, & Doran, 2013, p. 44). Yet one difficulty is that traumatized children may be focused on survival and a response to stress that includes fighting or fleeing from such authentic connection. It is a natural way to prepare themselves to minimize injury.

> The experience of developmental trauma means that the child is likely to have experienced disrupted relationships, involving experiences from loss and betrayal to actual physical harm. The resulting negative expectations of the intentions and actions of others make it likely that even positive interactions will be experienced as potentially ineffectual or harmful (Gregorowski & Seedat, 2013, p. 113).

With such expectations present, ways of connecting must be creative, involving, for example, using fun and humor. What may seem like play or simply hanging out to other children may be the most effective way to connect and engage with young persons who have experienced traumatic relationships in their past. Young people affected by traumatic experiences need "environments that immerse them in positive, repetitive rehearsals of healthy interactions and activities" (Gaskill & Perry, 2013, p. 186). Regulation begins with introducing safety and rhythm into daily life.

Systems with practitioners who are reactive to the symptoms of trauma unintentionally isolate young persons. Coercive practices such as point systems, se-

clusion, suspension, and removal of activities must be minimized if they are to best support young people recovering from trauma. These outdated coercive practices "by their nature reenact the experience of the child having to work external systems to gain even an illusion of control over [their] life, and are most difficult for the most seriously traumatized children" (American Association of Children's Residential Centers, 2014, pp. 102–104).

Connection and engagement are vital to relational care in themselves and not simply as a means toward surface goals such as school attendance, behavioral change, or reduction of self-harm. Although these things may improve the life of young persons, they can not overshadow the power of human connection and engagement in and of itself.

Implications for Organizational Culture

Since in some countries a large number of young people in care live in group settings, it is important to consider the implications of trauma sensitivity on organizational culture. Family settings are systems as well, so the same implications apply for the home environment.

Organizational leaders are responsible to shape a culture which supports trauma-sensitive practice. Policies and procedures play a role and so do the ongoing professional development and support of practitioners. Supervisors need to evaluate and hire practitioners who have natural talents and are willing to develop their skills to maximize effectiveness. Training and professional development should include knowledge and skills related to how to perform the following:

- connect with young people and families in a way that is sensitive to the impact of trauma
- build relationships that are collaborative rather than controlling
- reduce stress in the environment (especially by minimizing coercive and controlling interactions)
- promote a welcoming and hospitable environment
- engage young people in fun and meaningful activities that promote self-awareness, development, and self-regulation

See Figure 2 for suggested reflection and discussion questions to stimulate learning and application in home or group settings.

1. Think of a young person you have worked with who was impacted by significant trauma. What did you learn from the experience? What did the young person learn from the experience?

2. Consider experiences that may have been traumatic for you in your own experience as a young person. How did they impact the ways in which your viewed yourself or the world around you as you grew up?

3. What do you think of the concept of love in relational care? What place does it have in your daily practice?

4. Think of the numerous ways in which you interpret the actions and meaning of behavior during the course of a day. In what ways might you adjust or increase awareness of the ways you find meaning in those exchanges?

5. Connection and engagement were explained as an end rather than a means to an end. In what ways do you connect with young people with a predetermined goal in mind? How might you adjust to make your connection and engagement with them even more meaningful?

6. As a supervisor or manager, what programmatic changes might you make to move your program toward a more trauma sensitive-environment?

Figure 2: Questions for individual reflection or group discussion

Conclusion

Young people affected by trauma have valuable things to teach us, and they contribute to the world. Their healing—the restorative process of becoming healthy and whole—needs to be a focus in the various forms of support provided for them. It is up to child and youth care practitioners to support them and give voice to their experience. The characteristics of relational care, love, meaning making, and connection and engagement are central elements in supporting their restoration and recovery from exposure to childhood trauma. It is relational practice, when in-

formed and sensitive to impact of trauma, which best supports the healing process for young people—and it is such practice that restores the depth of human dignity and respect our world needs.

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CULTURAL VALUES AND PRACTICE WHEN SERVING CHILDREN, YOUTH AND FAMILIES: SHARING DEVELOPMENTAL CASE STUDIES

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ABSTRACT: Three case studies will be shared in this paper in the context of organizational values and practices implemented at the PHILLIPS Programs for Children and Families, located in Annandale, VA. The youth voices integrated in the case studies provide reasons for participating in special education and family strengthening programs. An overview of services and support received is given. Key challenges, successes, and emerging outcomes are considered. This study provides information on how to make organizational and cultural values come to life and how to recognize the positive youth development practices in special education and family strengthening services. This study also includes information on those working with crossover youth in special education day schools and family strengthening programs.

KEY WORDS: organizational, cultural values, positive youth development, case studies, youth voice, special education, family strengthening programs

Unable to find a safe and stable home with relatives, teenager Natasha has been placed into a foster care system for the first time in her life. She knows nothing about this system and she needs safety, stability, and nurturing in a family context. In another case study, Jefferson reports that he used to believe that he was dumb and violent. Why? Such words were directed towards him for several years by adults, including educators. In turn, Jefferson wondered if he had a future ahead of him. In another case study, Simon used to feel overwhelmed by life, educators, and adults; thus, he tended not to feel safe in many places, and he did not easily trust others.

The purpose of this paper is a) to share organizational and cultural values using the positive youth development framework as a backdrop, b) to use the case study and youth voice methodology to summarize the implementation and core components of two PHILLIPS programs, and c) to examine case studies in order to assess meaningful activities and experiences and review how such activities support families and guardians and positive youth development. The study is built upon the case study and youth voice methodology given that the case studies involve in-depth examination of three youth previously enrolled in a special education day school and the family strengthening program over at least two continuous years (Sukop, 2007). Using youth voice in the study also provides critical discussions on initial reasons for entering a program and for significant choices made

by youth that drive their concept of self. The research design includes structured observations, interviews with youth and family, check-ins with program developers, and reviews of past records and experiences.

Organizational Values And Philosophy

The two programs examined include the PHILLIPS' special education day school (known as PHILLIPS School-Annandale) and the Family Partners program. Family Partners is a program to strengthen families and communities because both are instrumental to child development and well-being (Family Strengthening Policy Center, 2007). Program headquarters are in Annandale, VA. The school has been in operation for 47 years, while Family Partners has existed for 20 years. The PHILLIPS organization is a private, nonprofit organization; staff are dedicated to serving the needs of individuals with emotional and behavioral disabilities and their families through education, family support services, community education, and advocacy.

The cultural values of PHILLIPS Programs for Children and Families for service delivery and continuum of care are utilized. The values represent a philosophy on how services should be delivered to children and their families. In practice, these values guide program development and decision making while prioritizing organizational practices. The cultural values were formalized in 2004 with the board of directors and staff. Printed as a one-page document, the values are permanently posted in offices and provided to staff on an annual basis. They include individualization, safety, commitment, community, compassion, integrity, and effectiveness (PHILLIPS Programs for Children and Families, 2010). Figure 1 provides a visual representation of the values. These values remain priority to the organization as a whole.

Closely linked to these values are important ideas associated with positive youth development, further ensuring that services and opportunities support all young people in developing a sense of a competence, usefulness, belonging, and empowerment (National Clearinghouse of Families and Youth, 2001).

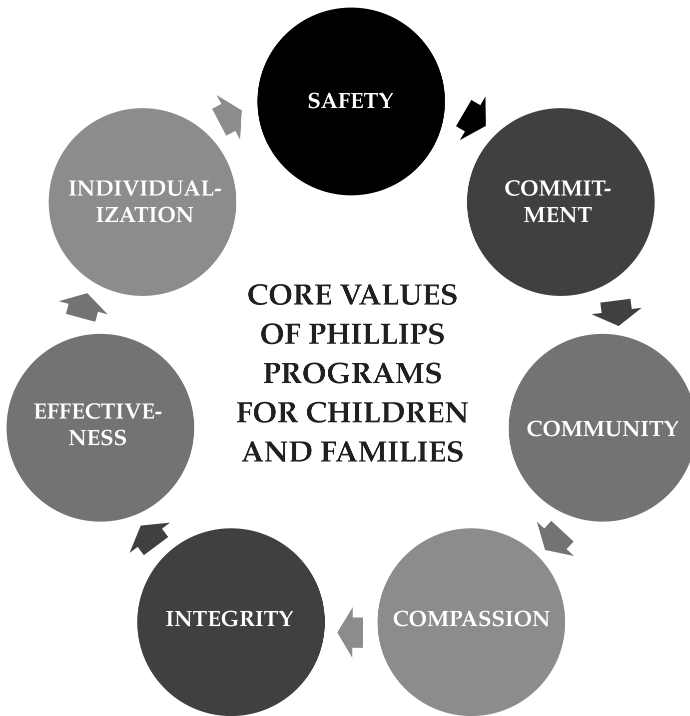

Figure 1: The Core Values of the Phillips Programs for Children and Familes

Positive youth development is a perspective that focuses on children and young people's capacities, strengths, and developmental needs—not solely on risks, problems, or overall compromising behaviors. It recognizes the need to broaden beyond problem reduction and crisis management to strategies that increase young people's connections to positive, supportive relationships, and challenging, meaningful experiences. According to Whitlock (2004), the positive youth development perspective is youth-centered, and comprehensive: "Young people thrive when they are developmentally supported across all sectors of the community—schools, youth-serving agencies, faith organizations, community governance, businesses, juvenile justice system, and more" (p. 1). Overall, the positive youth development perspective is a promising applicable approach for the development of all children and youth. A positive youth development perspective "reaffirms the need to invest fully in all youth. It urges us not to ignore the need to support those not in obvious trouble, while challenging us not to limit the expectations and range of supports offered to those who are" (Pittman, Irby, Tolman, Yohalem, & Ferber, 2003, p. 6). Figure 1 demonstrates how organizational values are linked to positive youth development, using key case study notes from the study.

Table 1: Core Values, Positive Youth Development Principles, and Case Studies ~ Overlapping Areas in the Study

PHILLIPS' Core Values	Research and Practice Notes of Study's Youth and Case Studies	Positive Youth Development Principles
Safety – We are vigilant in promoting the physical and emotional safety of all. We help people feel secure in our environment. We are responsible for preventing and correcting safety issues.	Case studies reveal that youth have safety in part because they believe that they can return to PHILLIPS when they need to, for example, during times when they need additional support. They experience safety through caring and meaningful relationships with teachers, counselors, and peers. They experience safety in terms of being given the time needed to express themselves to others. Staff employ critical skills such as active listening, patience getting to know youth and their families or guardians, working with home-based services as needed, working to re-integrate youth and families and guardians back into their communities, and building up strengths to avoid focusing on deficits in youth and their families and guardians.	Schools, families, and communities are engaged in developing safe, stable, and nurturing environments that support children and youth.

Table 1: Core Values, Positive Youth Development Principles, and Case Studies ~ Overlapping Areas in the Study

PHILLIPS' Core Values	Research and Practice Notes of Study's Youth and Case Studies	Positive Youth Development Principles
Integrity – We do what we say we will do. We tell the truth. We act thoughtfully based on the child's or client's interest, not on the organization's. Effectiveness – We aim for continuous improvement. We learn from our mistakes, as well as our successes. We make changes based on objective data to improve and evaluate the program.	Case studies reveal that youth and families and guardians trust PHILLIPS programs and services. Case studies reveal treatments operate with direct input from children, youth, and clients; in the school and Family Partners programs, team, IEP, and family conferencing meetings integrate family and guardian input. Youth voices in these meetings are supported on an ongoing basis, especially during discussion on transitions and existing programs. Staff want to learn more about the youth being serviced by programs and services. Staff work closely with parents to plan for youths' exit transitions and progress. Families and guardians are integrated into the treatment planning and IEP processes.	Programs and policies focus on the evolving developmental needs and tasks of children and youth, and involve youth as partners instead of clients.

Table 1: Core Values, Positive Youth Development Principles, and Case Studies ~ Overlapping Areas in the Study

PHILLIPS' Core Values	Research and Practice Notes of Study's Youth and Case Studies	Positive Youth Development Principles
Community – We include each other in decision making, problem solving, and having fun together. Compassion – We welcome and accept others. We empathize with others. We listen to and respect others.	Case studies reveal the value of working with youth, wherever they are situated and with consideration for their special needs and challenges. Case studies reveal the need to use various strategies to help youth find their voices and self-concepts. Case studies reveal the need for staff to have patience and form caring relationships with youth and their families and guardians. Staff are prepared to work with diverse children, youth, and families. Youth included as case studies were culturally diverse and staff were prepared to work with their various needs and challenges, and operate with kindness in terms of the respecting cultural diversity.	Children and youth are viewed as valued and respected assets to society.

Table 1: Core Values, Positive Youth Development Principles, and Case Studies ~ Overlapping Areas in the Study

PHILLIPS' Core Values	Research and Practice Notes of Study's Youth and Case Studies	Positive Youth Development Principles
Individualization – We respect the perspective of the child and family. We build the program to fit the child and family. We highlight strengths and embrace the potential of the children. Community – We include each other in decision making, problem solving, and having fun together.	By program design, the two programs work with strength-based approaches and strategies in partnership with children, youth, and families and guardians. Case studies show the value of working with child, youth, and family and guardian strengths and the value of developing new skills that contribute to emerging, positive youth development outcomes. By focusing on strengths, the youth in the study were encouraged to thrive, experience successes such as high school graduation, return to a home school, and move towards a better future as an adult. Case studies document strength-based and youth- and family and guardian-centered approaches, and case studies shed light on how clients' needs are diverse and contextual, which means that staff must respond to the needs and wants of youth and families as needed.	Children and youth are provided opportunities to experiment in a safe environment and to develop positive social values and norms.
Individualization – We respect the perspective of the child and family. We build the program to fit the child and family. We highlight strengths and embrace the potential of the children. Compassion – We welcome and accept others. We empathize with others. We listen to and respect others.	Case studies reveal a practice of working with each youth and their families and guardians based on their unique needs, wants, and challenges. Program directors from the school and Family Partners describe building a program and intervention around a child and youth instead of "fitting a child or youth into the program."	Children and youth are engaged in activities that promote self-understanding, self-worth, and a sense of belonging and resiliency.

Table 1: Core Values, Positive Youth Development Principles, and Case Studies ~ Overlapping Areas in the Study

PHILLIPS' Core Values	Research and Practice Notes of Study's Youth and Case Studies	Positive Youth Development Principles
Individualization – We respect the perspective of the child and family. We build the program to fit the child and family. We highlight strengths and embrace the potential of the children. Safety – We are vigilant in promoting the physical and emotional safety of all. We help people feel secure in our environment. We are responsible for preventing and correcting safety issues. Community – We include each other in decision-making, problem solving, and having fun together. Compassion – We welcome and accept others. We empathize with others. We listen to and respect others. Integrity – We do what we say we will do. We tell the truth. We act thoughtfully based on the child or clients interest, not on the organization's.	Case studies reveal the importance of caring relationships with peers and caring adults, and case studies revealed that youth move through a process of self-actualization, which helps them to find their voices, and define their future options.	Children and youth are involved in activities that enhance their 5Cs: competence, connections, character, confidence, and contribution to society.

Case Study and Voice Background

The study focuses on three youth who have experienced a transition away from at least one of the programs as well as an entry into another educational program that is less restrictive in nature. While the case studies cannot be generalizable to all youth in PHILLIPS' programs, they are designed to provide a deep understanding of a subject by "systematically gathering enough information about a particular person, social setting, event, or group to permit the researcher to effectively understand how the subject operates or functions" (Berg, 2007). In the past, case studies in special education research have shared students' personal mean-

ings and given voice to persons who have been historically silenced or marginalized (Brantlinger, Jimenez, Klingner, Pugach, & Richardson, 2005). Brantlinger et al. describe the use of case studies as narrative research, operating with the assumption that persons, including young persons, have important stories to tell about their lives such as their treatment efforts and assessment strategies for persons in special education. In program evaluation, others have found that storytelling is effective because "it accommodates diverse voices and perspectives, while making the most of the particular resources and ways of learning readily available" (Sukop, 2007). In relation to the California Endowment, Sukop (2007) suggests that sharing stories and voices respects and values diverse ways of knowing and learning—it is empowering and participatory. Sukop writes that stories work effectively with statistics and surveys and support communication with stakeholders and other community partners.

In special education, child and foster care, and the positive youth development field, youth voice is encouraged. The United States federal law known as the Individuals with Disabilities Education Act (IDEA) specifies how states and agencies should provide special education, early intervention, and other related services to children and youth with disabilities. According to the National Center on Secondary Education and Transition (DATE), the IDEA requires that students be invited to their Individualized Education Program (IEP) meeting, especially when transitional processes or decisions are being made. A positive youth development toolkit (National Resource Center for Youth Services, 2008) states that "as key stakeholders in their communities, youth are being formally recognized in many communities as important members of society, worthy of a voice in decision-making opportunities." According to Nybell (2013), national and international movements also promote a voice for children and youth to share their experiences with systems of care and a voice for social workers and others managing their cases or situations. In Nybell's research (2013), youth describe how they self-regulate when sharing stories, especially in the context of their lack of power and resources to find meaningful solutions in their families, schools, and communities. Quest, Fullerton, Geenen, & Powers (2012) used the case study and qualitative youth voice methodology (with seven youth) to explore themes like experiencing challenges, difficulties having clarifying relationships with family members and adults, having to make key decisions during times of uncertainly about services, and trying to become successful.

By design, the PHILLIPS School-Annandale and the Family Partners program work directly with children, youth, and families in educational and home-based settings. Both involve families or guardians, assisting families with accessing and coordinating needed resources and services. Both promote collective responsibility, commitment, and accountability for the well-being of children and youth, and both programs support families in accessing beneficial social capital as it relates to their children by creating trust and reciprocity, and providing information and

cooperation. Programs acknowledge processes in the child, youth, and family or guardian contexts. This has recently been identified as a growing need in the field of case study science for child, youth, and family work (Muñoz, Fasano, & Greenaway, in press). Muñoz et al. note that youth work should assess youth, family, and care contexts along with the presentation of a program's or intervention's core components. By documenting the programs, the study integrates personal and process perspectives with vignettes, and the data analysis provides information on how youth work is conducted.

Methodology

Data Gathering Process

Data were collected during face-to-face interviews with participants and families and guardians. The interview team consisted of two females who had previous interview and developmental experience. They conducted interviews in private areas, generally within the day school. In order to assess developmental activities, they attempted to conduct interviews with youth three to six months after their exit, for one interview per participant. Youth were not compensated for their participation. Interviews included open-ended questions addressing reasons youth enter and exit programs, program history with activities and interactions with staff, perceptions on personal changes, and overall emotional and social functioning. Youth were asked to sign a release form and were informed that their names would not be used and that participation was completely voluntary. All interviews were conducted at the Annandale campus.

Research Participants and Their Settings

Five adolescents were originally considered as part of the study. Qualifications for taking part in the study included a willingness and understanding of how to participate in the research, which involved audio and video recording, a comfort level with a formal interview process, and an ability to share experiences with the researchers, which required cognitive skill and development. The participating youth were male and female, with a mean age of 19 years and an average enrollment of five years in the programs. The sample composition was Latino and African American youth. In one case study, the participants acknowledged their enrollment in PHILLIPS' therapeutic foster care program, known as Teaching Homes, which provided family education training. Training sessions were for all participants, including foster youth and families and were in safe, nurturing, and therapeutic environments and with caring parents. The program serves children and youth, ages birth to 21, at time of placement, and services include case management, independent living support, respite care out of home, treatment and intensive level foster care, and teen parent placements.

PHILLIPS School-Annandale serves children and youth who require special

education services and support for educational, intellectual, and social-emotional disabilities. The school provides special education programs to roughly 170 youth. It serves males and females between the ages of 5 and 22, with a wide range of academic performance levels, and were determined to be eligible for services in one or more of the following categories: autistic, emotionally disabled, intellectually disabled, learning disabled, multiply handicapped, and other health impaired. The purpose of the school is to provide high quality special educational and related services to children who are unable to benefit from placement in a less-specialized school environment because of emotional disabilities, learning disabilities, and emotional vulnerabilities. It provides complementary training and consultation to their families. Related services include counseling, speech and language therapy, occupational therapy, and physical therapy. Administrators and all staff (e.g., counselors, therapists, behavior specialists, interns, one-to-one assistants, and occupational and physical therapists) operate with the belief that schooling should lead to competency in basic academic and survival skills, and to prepare for work, leisure time, and citizenship. The school environment provides a warm, therapeutic milieu in which instruction and related services can be adapted to accommodate each student's individual learning needs. The school relies on established empirical knowledge and is committed to using objective data in its approach to education and treatment. Therefore, there is no rigid adherence to any given set of procedures or methods. The program takes into account the interrelationship between the intellectual, physical, social, and emotional aspects of a youth's development. Thus, the school provides each youth with an individualized program of balanced activities developed and monitored by an interdisciplinary team. The teacher is the case manager of the children in their classroom, and all staff working with each child is a part of their team. During the 2012-2013 school year from September 1 to mid-June, the youth served by the school presented with the following primary disabilities: autism, emotional disability, intellectual disability, multiple disabilities, orthopedic impairment, other health impairment, specific learning disability, and traumatic brain injury. For this year, 90% of the students received counseling services while close to one half (47%) received speech therapy services.

PHILLIPS' Family Partners program was established in 1993 with the goals to support and empower children, youth, and families with mental health and developmental needs, to reduce family stress and dysfunction, to build on strengths and resiliency to stabilize families, and to create safe home environments. The staff build on family strengths and children's resiliency to address family stress or dysfunction by using a wellness and resiliency philosophy, which is the best approach to bringing stability and health to a family. The program follows the "family voice and choice" philosophy to ensure that families participate and guide their services which overlaps with national wraparound principles (Osher, 2008). In terms of key outcomes, Family Partners teaches the families or guardians the needed knowledge and awareness of their children's or families' situations and

teaches new skills to be better able to manage the stressors that lead to increased stabilization of child and family by improving their functioning. The program offers home-based counseling and intensive individualized family and child plans, and utilizes tools such as motivational interviewing and meaningful developmental activities to strengthen families and youth. The program targets children and their families who are experiencing serious family stress or dysfunction, sometimes with the risk of a child's removal from a family due to problems that are too complicated or severe for the parents to solve without intensive support. Problems may include a child's functioning in school, at home, or in the community. These problems may appear in conjunction with mental illness of the child or parent, developmental disabilities, emotional-behavioral disabilities, learning disabilities, poverty, substance abuse, attachment disorders, and sex offenses. For those children who have already been removed from the home prior to working with Family Partners, staff work with the family toward reunification. Family Partners strives to successfully serve a widely varied population that is at high risk using its ability to match staff with appropriate skills to a population varying widely in age, income levels, and ethnicity.

In practice, Family Partners counselors meet with the family or youth two to three times per week for individual and family therapy and spend additional time providing case management and wraparound services. Inclusion and engagement of youth and families in all parts of the service is of paramount importance in service delivery and developing goals, for example, in treatment plans. Youth and families develop their goals and sign their treatment plans to assist in their taking ownership of their plans. Time and attention is devoted to wraparound services and advocacy to support the families' needs within a community system of care as Family Partners transitions. The program has also been engaged in developing its own evidence-supported model with an independent consultant, Pam Meadowcroft. Key short-term outcomes for children, youth, and families include a desire to improve, the belief that change can happen, and the feeling of being connected to and trusting to natural supports. Other outcomes include knowledge and skills to meet goals on treatment plans, access key resources and services, communicate, problem solve, and make positive decisions. The program provides flexible, individualized services based on needs and progress, and 2 to 10 hours per week of face-to-face contact with program youth and their families and accessibility anytime day or night to all program participants. Several working assumptions are used by staff: that family can be the best place for children and youth to grow and develop and that families or guardians want what is best for themselves and their children.

The following case studies of Natasha, Jefferson, and Simon illustrate how PHILLIPS programs come together and serve youth and their families.

First Case Study: Natasha

The first time Natasha sat down for the interview session she had already given some thought about how much she would share about herself and her experiences. Bringing up too many negative experiences seemed too difficult for her, especially not knowing the research team members; however, she felt comfortable sharing some of her experiences. Being and functioning with a positive persona or tone and having resiliency remained important to Natasha.

Natasha entered the Family Partners and the therapeutic foster care programs during her teen years and remained enrolled for over five years. Her entry process involved placement into the foster care system due to family instability. She stated that she needed a safe home, and she wanted to "continue with life." When asked about what worked well, Natasha mentioned three core components: helping guardians to be better parents, mentoring youth and families, and promoting independent living skills.

She said she believes that supporting parents to be better at raising children and youth helps everyone in the family; it helped her to relate better to adults and vice versa. With mentoring, she felt forever connected to PHILLIPS and caring staff. "I can always come back . . . this is my second home." She knew where to go for support in times of need. She stated that she knew this because "I know they helped me . . . I have support here." The developmental activities that worked best for Natasha included mentoring by caring adults, having a safe and nurturing place to live and thrive, and being supported to attain her high school and postsecondary education. She liked the way that the program provided mentors to both the home and foster parent and to her on a monthly and ongoing basis. With mentoring Natasha gained a better understanding of the child welfare system and what it entailed to connect with similarly situated children and youth. She liked working with her peers and teaching children and others about how to function in the contexts of family, school, community, and work. Later during her time with the PHILLIPS programs, she served as an older youth mentor and teacher to children, focusing on independent life skills, resiliency strategies, and connections to themselves and others in their communities.

Natasha thrived by building social connections with caring adults and adult mentors, feeling free to share information about her dreams to graduate with a good high school diploma and to continue her educational career. While she allowed herself to feel sadness about her own lack of a strong family situation, Natasha focused on being positive and on achieving her goals in educational attainment, getting good employment, and staying connected to caring people in her life. She would make diffi-

cult decisions about friends, for example, keeping supportive friends close by to support her decisions and belief systems on being independent and having educational achievement and economic stability. She had to make economic decisions, too, for example, about keeping a savings account and balancing her budget when it came to needs and wants.

Natasha benefitted from mentors who also served as counselors because she recalled needing the one-to-one counseling from time to time and felt the family counseling opportunities were also helpful for everyone. Natasha felt she had strong access to mentors and counselors when every key challenge arose. It was during these times that she would request a visit from staff, and the visit would happen seamlessly. "It was a big help to work with counselors," she told us. When it came to the mentoring program, she outlined the benefits: Mentors helped her to stay positive even during the unexpected struggles; they listened and gave her good advice; and they made her feel connected to others, including the mentors, the program, and her new foster family. Natasha felt she could trust others because of the mentors, especially because they were present and there for her in good and bad times, and they would not judge her.

Natasha liked activities that were associated with learning about how to become more independent—"by doing." She credited this type of approach or training with teaching her how to balance a budget, open a bank account, keep a good credit score, and plan a program with staff with meaningful content and good guest speakers. Overall these activities were "helpful and fun to do," according to Natasha. They made learning these skills and behaviors easy and fun. Part of her strategy towards becoming successful was taking advantage of programs and services provided. She described herself as wanting to learn how to be independent at a very young age because this is important for children and adolescents: "I learned about not wasting my money," "We learned about using coupons," and "Did you know that you don't need a credit card to have a good credit score? You can get a secure card from your bank." For her, the independent learning activities made sense and allowed her to better understand the skills she needed to have in her life.

One key underlying theme for Natasha was having trust—she came to trust caring adults. She credited PHILLIPS' programs with this outcome. Further, she believed that the skills she acquired matter. For instance, she opened a bank account and she knew the rules in banking. She also learned how to complete an apartment application. She said, "They were helping you so much . . . helping you get through life." Hopes and dreams were part of her discourse. She said she hoped to work with children similarly situated, those needing family support and stability. She hoped to serve in a professional field to advocate for child welfare and

system reform. In this process, she knew that she had a great deal to learn, but she was driven to learn and to give back to other children, too. Her caring persona was strong, and her educational attainment and employment experiences were already on her path.

Natasha's foster parent was honored and surprised to hear the words of admiration and gratitude. Her parent was modest in acknowledging several of Natasha's successes such as getting through high school and getting a car. These successes were viewed as expectations for Natasha. In the end, her foster parent was proud of Natasha's life and supported her educational, employment, and life benchmarks. The parent seemed to especially value parent training sessions. She showed love towards Natasha when she heard her talk about her experiences, challenges, hopes, and dreams.

Practice Notes. The case study illustrates the ways that youth do have important stories and experiences to show the ways that youth are resilient and trying their best not to give up on themselves and others. Natasha's case study illustrates the complexities of working with youth who have experienced harmful, biological family members and really want only what makes them happy. This includes learning how to help and trust others, getting a good education and job, and learning to have hopes and dreams, to be able to live independently, and to set doable goals.

Natasha's counselors were available day and night, making sure that her educational and personal aspirations were addressed and integrated into her treatment plan. They provided guidance to her foster parent and to Natasha for meeting transportation needs, making better choices about future planning and friends, having positive supports, friends, and colleagues, and remaining focused on long-term goals. Mentors provided the additional support Natasha needed to get help that was needed and feel connected to more than one caring adult. Coming together with peers, for example, as part of a formal training session or as a peer facilitator, helped her feel connected to others and her community.

Regarding time and timing, Natasha was encouraged to think about her timeline for exiting her guardian's home and care. In particular, family and care-team discussions focused on how to streamline postsecondary educational activities with working outside of the home.

Natasha was part of the team effort to make key decisions about high school, and postsecondary education. She knew that coming back to PHILLIPS, the staff, and counselors would continue to remain an option. She knew where to go to for concrete support in times of need. Natasha also knew that she mattered to people associated with the PHILLIPS programs.

Evaluator Reflections. It was important to have a good balance of asking questions, probing, and keeping an appropriate pace with Natasha to process the inter-

view questions and responses. With the audio and video recording equipment on, Natasha remained reserved about sharing details of her experiences. She became more at ease when the equipment was put away. She needed to control how much she shared, and she kept some of her information private during the interview session. For her, trust was critical, and sharing her story needed to feel right and valued. This may have happened, in part, because of her presentation of self, which remained as a positive person with hopes and dreams, and it may have happened because of experiences when recalling the point of entry into programs and services. Yet while she was guarded, she was willing to answer most interview questions. In the end, Natasha viewed the interview session as part of her own process to gain her voice after being a program participant. With this in mind, the research team was mindful of being respectful and kind, ensuring that no inappropriate tactics or harm were part of the data collection procedures. The data collection for Natasha occurred over three sessions meeting in a non-office, a relaxed conversational setting. The session with her foster parent was also informal.

Second Case Study: Jefferson

During his first year at PHILLIPS School, Jefferson documented one of his favorite quotes in a school writing journal: “Do What You Feel.” With the support of PHILLIPS, it took over one and a half years for Jefferson to feel comfortable with being himself in the context of struggles and successes in his community, family, and home school. He decided to be a better person (on purpose) by being kind to his family, helping others who looked up to him at school and in his community, and by realizing that people really cared about him. Jefferson explained his process: He decided that being one of the meanest persons on campus was no longer a goal for him. Instead, he wanted to be happy, have caring friends, trust his teachers and adults in his life, and he realized that he mattered to himself as well as to his community, family, and teachers. He wanted to thrive, and there was no stopping him. It was at this turning point that he advanced in his high school studies, developed a positive perception of himself, and showed a willingness to take control of his future and happiness. “I can say, people look up to me—outside of school,” Jefferson told us during his final days enrolled in the PHILLIPS School-Annandale.

What worked for Jefferson? He expressed several reasons which helped him feel like a whole person. Consistency, for example, in what was expected from him academically and behaviorally, was transparent and reinforced on a daily basis. He worked with teachers and his team to comprehend consequences and rewards for better behavior and grades. The staff helped him—by listening to him talk about what was bothering him—this really mattered to him. Strong, positive messages and interactions with staff and school friends helped him to see that he was

important to others. Staff paid attention to him but not just for negative behavior but also for positive behavior and insights. His attendance at school mattered to his teachers and others. People began counting on him to set the tone within the classroom; people began looking up to him as a leader for himself and others. Caring relationships with staff helped him to trust and understand that he was not alone in his life experiences. Staff reminded him of their availability to help him with classwork and their willingness to discuss key concerns with family. Staff provided Jefferson with what he needed—sometimes it was a quiet time to talk, a hoodie jacket or jeans, or a big hug or high five. In a memory book, he wrote that his teacher "was like a father."

Key developmental activities helped him to learn to be part of something bigger than himself. For example, a school-based sport activity helped him to remain committed to a team and to understand that peers could really care about one other. Participation in a school-based student organization helped him to see his leadership qualities which he had not seen before. He learned not to be afraid of his own potential. Participation in peer mentoring opportunities encouraged him to care for others, and this caring became a part of his persona. At PHILLIPS, he was strongly encouraged to take his academic studies seriously, and the labels of "dumb" and "violent" were no longer used against him. Instead, serious one-on-one conversations were being held with him about his hopes, dreams, and his potential to return to his previous school to complete his high school education.

During his time with the PHILLIPS school, Jefferson reported feeling loved by teachers and peers, feeling okay about being helpful to others, and learning important life skills such as how to pick better friends, how to cook a meal, and how to be respectful to his family members. His hope was to continue to let his true self-identity emerge and to continue to pick good friends, including those who cared for him and wanted him to excel in all of his endeavors. He was living out more of his dreams every day, and he planned to leave PHILLIPS school in order to return to his home school and quickly graduate with his high school diploma and move into a postsecondary setting. As part of an exit process, many people wanted more time with Jefferson. Teachers wanted to know what worked well for him. Students did not want him to go. His parent was so happy to see this new Jefferson.

His parent shared a poem about him. What did Jefferson's parent see in him at that time? Strong opinions about what was important to his future, better decisions, a focus on a better future, willingness to be a mentor to others, a willingness to talk about what mattered to Jefferson, and happiness. Team Jefferson emerged, and his parent and siblings were

> all on board—Jefferson was a success story.
>
> When asked to share what he learned as a result of his time with the school, Jefferson said he learned to mind his own business, help others, control his emotions, have honesty and loyalty, trust people, see that school staff cared for their students, and behave differently at home and his community, which included avoiding drama and keeping his emotions under control. These were critical and positive youth development outcomes. He stated, "I love being myself," and "I'm not in this world for the fame or the greed but I'm in this world because I'm highly created to lead . . . my place in this world is to be a leader."

Practice Notes. Jefferson's case study illustrates how consistent support, positive messaging, and authentic caring remain critical for youth who need to feel like they belong in our social institutions and communities. For Jefferson, such strategies worked to support his emerging expression of true-self to his family, peers, and community. This case study also suggests the powerfulness of youth finding their narratives that promote caring for oneself and others, and knowing that their futures can be positive. In an effort to gain a better sense of this story, I conducted outreach to several staff. They described a difficult transition to the school program that changed over time. They felt that consistency presented in a positive way was important to his success because he needed to feel connected to the PHILLIPS environment, and this needed to happen as quickly as possible. Staff began to understand that friends in his community served as barriers to his overall success, so they worked with several new cohorts to establish meaningful friendships. Staff recognized positive outcomes for Jefferson, and they shared their perceptions with him using one-to-one conversations. The staff wanted Jefferson to know that they were witnessing positive changes in his attitudes, behaviors, and future visioning. In the end, there was buy-in when Jefferson realized he was becoming a youth with positive outcomes, for example making better choices and improving grades, social and emotional functioning, and civic engagements.

During the interview session, Jefferson articulated his personal and clear, turning point—when he finally decided that he was going to do better in school, and with family and friends. "I decided that I was going to start being myself," he told a staff member. He stated that he knew he needed to change, on purpose and for the better. He was not prepared to fail in his studies and his future. It was at this turning point that Jefferson went back (in his mind) to the encouraging words from behavioral staff, teachers, counselors, and his parent—they had told him he was a great kid and that people were waiting for him to be himself, thriving and present in his life. The staff considered this in order to understand how youth can make their own decisions and that personal buy-in helped drive Jefferson towards positive outcomes.

Evaluator Reflections. Jefferson's voice and story were easy to follow and share

with others. In fact, staff wanted to hear his story shortly after he exited the school program because they had seen significant change in him from his first day to his exit date. They wanted to share lessons learned with each other and with other students. The interview helped them understand youth care practice, youth voice, and positive youth development. They remain connected to Jefferson and his parent, monitoring his next steps and being prepared to provide support, as needed. For example, his parent may need advice on a postsecondary institution, and staff are available to help with questions and concerns. In this way, they remain connected and act as an extended family for a long time.

Third Case Study: Simon

Age 13 was a turning point for Simon: His growing sensitivity to noise and light, and his inability to meet new people and negotiate spaces prevented him from being part of society. At the same time, his intellectual ability was growing. He and his parent searched for school and family services that could accommodate his need to better function and relieve stress. "I was in my difficult time then," he told us later. His parent took an active role to locate a special education program and family-strengthening program to benefit the entire family. The parent had a little shyness about asking for help and securing quality services for Simon and the family. This was a new role for Simon's parent, becoming a strong advocate and making sure that important changes for the family were clearly understood.

Family Partners' services ensured that the positive changes happening at the school were realized and supported at home. "They helped us—as a family," Simon's parent said during the interview. Then, the school program provided the right amount of time and academic challenge in an environment that was becoming safer to Simon. The school had quiet time and appropriately paced programming, including the time needed to learn how to make friends and work with different teachers and staff and the time needed for Simon to process and experience both highs and lows in his educational and social experiences.

The highs came when Simon spoke several words during the school day—a process that took over two years. "Most places tried to push me to talk, and it did not work; here I could take time I needed and it happened on its own," he told staff. On that day, the school called the parent: "They called me, and I was so happy; he spoke; and that was the first time," his parent said. Other highs came when he excelled in his academic studies. His teacher saw active engagement in special projects and willingness to work on mathematics and geometry at or above his grade level. His teacher saw a focused youth who began to let little things not bother him so much, such as other students voicing

their own opinions or not allowing Simon to work on his studies at his own pace.

The lows would come during important transitions that entailed moving into the building spaces, meeting new persons, or learning new content. Eventually, these transitions would be successful ones; however, they took time.

The activities that helped Simon the most were being taught social and professional skills such as cooking, getting mock applications completed for an apartment, taking public transportation, and acting correctly at his jobsite. It also helped when staff provided realistic explanations about the expectations at school, family, community, and work, instead of simply being told what to do. He said later, "I can be stubborn, but I don't want to cause problems . . . I like being shown the reason about what you should and should not do."

One key social skill acquired was learning to accept others for who they are, compared to wanting everyone to think "just like me." Simon learned that he could avoid conflicts with others by telling himself that everyone was allowed to have their own opinion and perspective. He learned, "We don't all have to agree the same way."

Equally important was the skill he described as "being persistent"—when he decided not to give up on himself during his struggles and to become part of the social environment. He liked getting career education experiences and trying out different types of jobs; he liked traveling off campus to work in different work settings; he liked having other friends doing these tasks, too.

During discussions with staff, Simon's persona was evident. For example, he was articulate, he spoke slowly, his thinking was methodical, and his social values were clearly intact. He liked sports and being with his family; he wanted to learn a foreign language; he was happy that he had been at PHILLIPS program; he wanted to work and go to a postsecondary school; and, he was hopeful in what he wanted for his future. His parent was proud to be part of the interview process alongside Simon and felt like the program had been the last option for success for Simon. The parent was slightly anxious about Simon's next steps after high school graduation but was ready nonetheless. After the interview, Simon's parent informed PHILLIPS of several interviews planned for Simon's getting a full-time job with the federal government. His skills of keeping items well-organized in the workplace and willingness to learn new job requirements helped him to secure the work, according to the parent.

Practice Notes. Simon's parent said that Simon could have been institutionalized because of his extreme fear and anxiety of people and places. Before entry

into PHILLIPS, the family believed that no strategies were available to help him towards interacting with the outside world. This case study illustrates the ways that youth need time to express their own needs and feelings, and it reinforces the value of helping youth to find their good qualities, too, for example, having patience with oneself and others or being persistent in having a better life with family and friends.

In terms of practice, this case study suggests that listening and patience with youth is required when helping them find ways of expressing themselves, and learning to cope with their familial, social, and peer environments. The team effort for Simon was comprehensive as staff from two PHILLIPS programs had to work together to support family and school processes. Simon's parent was particularly connected to Simon's teacher, so the teacher was a good point of contact for the family for a long time. Simon was enrolled in PHILLIPS' program for over five years, and working with Simon and his parent took time and patience, leading up to Simon's high school graduation.

Evaluator Reflections. The case evaluator worked with the teacher to build trust with Simon's family. Patience with the pace was required, allowing for breaks and letting Simon and his parent finish one another's sentences and thoughts. Simon's parent also expressed anxiety about high school graduation and needed support from the Family Partners staff. Simon's teacher was notified about the anxiety. After the interview, Simon's parent provided feedback on Simon's status, which was helpful in terms of monitoring the next steps and potential positive youth development outcomes. At the same time, there was a strong sense of gratitude towards PHILLIPS from Simon's parent.

Conclusion And Practices

The youth included in our case studies felt safe in programs, services, interactions, and caring relationships. Youth believed that they could return to PHILLIPS if they needed to. They experienced safety through caring and meaningful relationships with teachers, counselors, staff, and peers. They experienced safety in terms of having the time they need to express themselves to others.

In terms of trust, the case studies reveal that youth and families and guardians trust PHILLIPS programs and services. The studies reveal that their treatment and educational plans work in partnership with the youth, families, and guardians. For example, school, team, and IEP meetings integrate family and guardian input. Youth voices in the IEP processes are important, especially when discussions focus on transitions and existing programs. The case studies research shows that staff work with youth—wherever they are situated and with consideration to their special needs and challenges. With this in mind, we found the use of various youth-centered strategies helps youth to find their voices and learn more about themselves — in other words, developing their self-concepts.

With the various youth, staff practiced patience and formed caring relation-

ships with youth and their families and guardians. Working with strengths of the youth and families was apparent in the case studies. In particular, a strength-based approach helped youth to develop new skills (e.g., speaking up for themselves, increasing independent living skills, etc.), which contributed to their emerging, positive youth development outcomes. By focusing on strengths, the youth were encouraged to thrive and be successful, for example, graduating from high school, returning back to a home school, and becoming focused on a better future as an adult. Case studies reveal a practice of working with each youth and their families and guardians based on their unique needs, wants, and challenges. When discussing the different programs, directors for the school and Family Partners continue to describe building a program or intervention "around a child or youth," instead of fitting a child or youth into the PHILLIPS program.

Case studies further reveal the establishment of strong, caring relationships with peers and caring adults. This practice promotes youth moving through a process of self-actualization, which helps them to find their voice and define better future options. Thus, the case studies document strength-based, youth-centered, and family-centered approaches when working with youth and their families. The case studies show that PHILLIPS staff must be able to respond to the diverse needs and wants of youth and families as needed. The practice at PHILLIPS has been flexible in striving for positive outcomes. Organizational practices and the PYD approach help staff with listening actively, having patience to get to know youth and their families, working with home-based services as needed, working to reintegrate youth and families back into their communities, and building up strengths to avoid focusing on deficits of youth and their families and guardians. Because youth in our programs and youth in these case studies were culturally diverse, the study reveals that staff must be prepared to work with various needs and challenges, and to support kindness in terms of the cultural diversity of youth and their families and guardians in the PHILLIPS programs and settings. Finally, the PHILLIPS staff clearly indicate that they value youth voices and want to learn more about the youth being serviced by their programs and services. In terms of technical work, the staff has worked closely with parents to plan for their youths' exit transitions and progress. Families and guardians have valued being integrated into the treatment planning and IEP processes, which is a standard practice in the two programs.

This study used the case study and youth voice methodologies to explore emerging practices in the special education day programs and family strengthening programs. Such programs have goals and objectives to accomplish positive youth development outcomes and success stories. The study documents key aspects of cultural values that are supported by positive youth development. Interviewing the youth and their families and guardians revealed what activities youth valued and how the families viewed their situations. Staff at PHILLIPS hope that additional research and documentation of successful practices and contexts of child/youth/family/guardian can expand this type of study and work towards

program evaluation and improvement.

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TRAUMA-INFORMED SELF-CARE FOR CHILD AND YOUTH CARE WORKER

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This article presents a framework for understanding, developing, and applying a trauma-informed approach to staff, team, and organizational self-care in youth serving organizations. The article draws on current research in the areas of Adverse Childhood Experiences (ACE), Trauma-Informed Care (TIC), Trauma Stewardship, resilience, and The Sanctuary Model. This approach will help child and youth care workers to develop a long lasting, effective trauma-informed self, team, and organizational care plan. The first article focuses on worker trauma-informed self-care, and the second on team and organizational approaches.

Since there are limits as to what can be comprehensively covered in a short article, I will supply an extensive list of key references and resources relevant to self, team, and organizational care. Many of these are directly downloadable from the Internet. Thus, I do not attempt to answer all the issues but encourage readers to explore the various resources and ideas and apply them where relevant to the readers, their team, and organizations.

The Adverse Childhood Experiences (ACE) Study and Its Implications for Child and Youth Care Workers

The ACE study was undertaken in the United States in the late 1990s (Felitti et al., 1998). The United States Center for Disease Control and Kaiser Permanente, a health insurance company, collaborated in the 10-year study involving 17,337 adults, focusing on the effects of adverse childhood experiences over the participants' life spans.

The questions in this survey related to a number of adverse childhood experiences:

- physical, emotional, or sexual abuse
- neglect or abandonment
- loss of parent due to divorce or death
- alcoholism or drug addiction in the family
- family violence
- lack of food and basic needs
- family member in prison
- family member with mental illness.

The survey respondents were largely white, middle class, educated people from professional and skilled trades backgrounds. The study found that around one third of those surveyed had no adverse childhood experiences, with 16% having four or more adverse childhood experiences, and 9% having five or more ACE. This and other research have shown that the more adverse childhood experiences encountered by an individual the higher the correlation with later poor health and risky behaviors (Cooper, 2007; Hodas, 2012a).

So what were the ACE effects on this relatively well-off group? Felitti et al. (1998) note that the impacts of such adverse childhood experiences are neurological, biological, psychological, and social. These can include neurobiological changes in the structure and functioning of the brain neurobiology and related cognitive, emotional, and social impairments at various stages of development. The earlier in life the trauma occurred, the more pervasive these changes can be. These impairments can lead to health-related risk behaviors in order to cope. Such behaviors may include eating disorders, drug and alcohol abuse, inappropriate sexual behavior, self-harm, and violence, creating severe and persistent behavioral health and social problems including obesity, heart disease, and smoking, which can lead to early death.

Compared to this first relatively well-off group, what is the level of ACE in the at-risk youth populations that child and youth care workers deal with? One study found that in a school in Washington state serving lower income students, 10 of 30 children had an ACE score of four or more (Anda, 2012). The prevalence of data indicates that the majority of adults and children in mental health treatment settings, and welfare, correctional, and addiction services have major trauma histories. Cooper (2007) noted that in the United States "Many children and youth experience trauma. Depending on their circumstance, 25–90% of children and youth experience events that leave them traumatized" (p. 1). These include up to 50% of children and young people in the child welfare system, from 60–90% of youth in juvenile justice settings, and 59–91% of children and adolescents in the community mental health system (Cusack et al., 2003; Cooper, 2007; Hodas, 2006; 2012a; Michelfelder & Swoboda, 2012).

Obvious Causes of Trauma

Experiencing such trauma can lead to immediate responses in children and youth, such as being hypervigilant to danger, the narrowing of visual and mental focus resulting in restlessness. There may also be the opposite reactions of feelings of helplessness, lethargy, and freezing, and also denial and dissociation (Hudson, n.d.; Levine, 2008; Michelfelder & Swoboda, 2012). Other less immediate responses can include disturbed sleep patterns, nightmares, flashbacks, or "daymares." Other responses include being hypersensitive to noise, light, and smell, being easily startled or emotionally over-reactive, and having mood swings. There may also be a general inability to deal with stress and an overwhelming sense of shame and lack of self-worth (Hodas, 2012a).

Longer-term responses to adverse childhood experiences can lead to panic attacks, phobias, and avoidance of certain situations. There may also be the inability to think and concentrate easily, memory loss of the incident, or a sense of being spaced out. Some adolescent trauma survivors may display over time drug and alcohol addictions, uncharacteristic sexual behavior, or the seeking of stimulating and dangerous situations. At the same time, trauma survivors may have a well-founded perception of impending death and display self-harm or explosive aggression. Sometimes as a result of attachment disruption such people show an inability to love, nurture, or form positive relationships.

Trauma responses can be stable—that is, continually present—or unstable, reemerging when triggered by certain situations. They can also remain hidden for long periods of time and then suddenly appear at key life transitions or periods of crisis (Levine, 2008). Terr (1991) noted two sorts of trauma: type one, which involves a single incident, and type two, which involves multiple traumas over an extended period. However, in passing it must be noted that some trauma survivors acknowledge that often from trauma arises personal growth and resilience or hardiness, which is the so-called *salutogenic effect* (Conchar & Repper, 2014).

Trauma Mastery

One of the most intriguing and sometimes baffling responses by service users to adverse childhood experiences and other life experiences is trauma mastery. For many of those who survive trauma, one of the most difficult and damaging aspects of such experiences is the perceived total lack of control. Van Dernoot Lipsky and Burk (2009) noted "What humans often do to reconcile the lack of control is to create and recreate situations as similar to the traumatic incident as possible. We seek to turn a traumatic situation in which we once felt powerless into a new situation where we feel competent and in charge." Furthermore, "We tell ourselves that this time there will be a different outcome. Or so we hope . . . We act reflexively, attempting to salvage some sense of control" (p. 156).

However, in an attempt to gain trauma mastery over their circumstances, service users may fail once more to regain power and control and further increase their sense of powerlessness and trauma reactions. At the most extreme responses, unconscious attempts at trauma mastery may trigger returning to dangerous settings and the possibility of greater physical and psychological damage. Some service users may continue to live or remain in dangerous situations or attempt to provoke negative behaviors from others against themselves. However, it should be noted that service users may also actively seek to remove themselves from such trauma-invoking situations and not try to gain trauma mastery at all. The avoidance of trauma-related cues and memories is one of the four symptom clusters that comprise posttraumatic stress disorder.

In light of the above information, those in the system have a history of traumatic stress, and we need exercise universal precautions by creating systems of care

that are trauma-informed (Hodas, 2006; 2012b). So increasingly trauma-informed services are being built around this concept of universal precautions. In some rare instances this may not be the case, but it seems wise to take this approach until proven wrong.

Adverse Childhood Experiences Histories in Child and Youth Care Workers

How different are the adverse childhood experiences of child and youth care workers from those they serve? The current limited research on the trauma history of human service workers (Black, 2008; Maunder et al., 2010; Michalopoulos & Aparicio, 2012; Conchar & Repper, 2014) has found a wide range of adverse childhood experiences from a low of around 30% to a high of 76% (one in three of the middle-class group had no adverse childhood experiences history). Those surveyed included youth workers, counselors, faith-based workers, psychologists, social workers, health staff, and lawyers. Anecdotally, many of these practitioners have mentioned a trauma event or events as being the major motivation for wanting to enter child and youth care work or other human services work.

In light of the above research around staff ACE, many service providers have similar backgrounds to those they care for. Bloom and Farragher (2011) commented, "The bottom line is that there is no clear dividing line between 'us' and 'them,' between the people who need help and the people who offer help. Frequently, the helpers are themselves wounded warriors of a different sort" (See also Auw, 1991, 1999, p. 68).

Because of these relatively high levels of adverse childhood experiences in human services workers, including child and youth care specialists, it is vital to take into account the trauma histories of staff to ensure their well-being. Because of the young people they serve, there must be an awareness by employing organizations of the strong possibility that many employees themselves have trauma histories and will need additional supports. Issues of employment law and employee confidentiality may hamper the efforts of organizations to address these issues unless innovative approaches for Trauma Informed Teamwork (Bowen, 2015) are used for the supporting and training of child and youth care workers. This topic will be covered more fully in the next article.

Part of this approach is to provide the opportunity for child and youth care workers to examine how their own childhood and later life experiences may affect the way they deal with stress and trauma in themselves and the people they serve (Conchar & Repper, 2014). This is not always easy, as Reese and Loanne (2012) point out, "Our early years are fundamental in our development. Paying attention to the different critical incidents of these early years is in many ways hard . . . work, but it can also be very freeing and healing . . . " (p. 83). Arledge and Wolfson (2001) refer to such staff as "clinician survivors" (p. 92). An important part of such early childhood experiences for current staff can be their types of early attachment to their caregivers or parents. Such attachments can affect staff members' later expe-

riences of how they care for themselves and others (Scazzero, 2006; Bennett, 2008; Simmonds et al., 2009).

Such an examination can be encouraged within the organization in a number of supportive ways, including external mentoring, supervision, and therapy, either done individually or in small groups.

Aspects of Four Lenses That May Be Key in the Way One Cares for Oneself and Others

When child and youth care workers have a significant exposure to ACE, they can be more affected by the behaviors of the youth and children they serve than other staff who have no, or fewer, ACE. Even though the staff may not be diagnosed with PTSD, their behavior may reflect some of the hallmarks of this stress-related disorder. Vicarious traumatization is a negative change that occurs within those helping others who are trauma survivors (Saakvitne & Pearlman, 1996). Vicarious trauma is about having too much—too much trauma, threat, and feeling overwhelmed and dehumanized. Reese and Loanne (2012) suggest that there are four particular lenses that can help identify important aspects of one's early formation:

(a) one's family history,

(b) one's historical and cultural context,

(c) one's social base, and

(d) one's spiritual background.

Parts of these lenses are the various critical incidents people face during their early and ongoing development. "A critical incident can be any key relationship, event, or circumstance that has had significant influence in shaping your life, whether that incident was positive or negative" (Reese & Loanne, 2012, p. 96). These early experiences may then become the default position in the way people treat themselves and those they care for. Because of these experiences, people "Tend to favor certain areas of self-care and neglect others, depending upon our personal preferences" (Harris, 2001, p. 260).

It is important then that in pre-service training, ongoing professional development, supervision, and mentoring that these four lenses be gently and respectfully examined on a regular basis. This needs to be done in a way that does not retraumatize the worker or team (Bowie, 2013).

Our Current Life and Work Experiences

A fifth lens should be added, that of one's current multiple relationships at a personal, work, and client level. Stamm's (2010) Professional Quality of Life Scale (ProQOL) is a useful tool to identify the impact of these various areas. Such relationships can induce a number of experiences, both positive and negative, that impact the life and work of youth and child care specialists. Let us now have a brief

look at compassion satisfaction, compassion fatigue, burnout, posttraumatic stress disorder (PTSD), and vicarious trauma.

There is much information and many resources available on these issues, but a trauma-informed perspective is lacking on them (Child Trauma Academy, n.d.; Skinner & Roche, 2005; Bowie, 2008; Pearlman & McKay, 2008; Volk, 2008; Conrad, 2010; CME Resources, 2011). These show how a trauma-sensitive framework can support and encourage positive experiences and minimize the impact of negative incidents.

Compassion Satisfaction–The "Good Stuff"

Compassion satisfaction arises from the positive aspects of helping related to providing care for and with others within a supportive team and organization. It is also influenced by the workers' beliefs about themselves and their views on giving and helping.

Compassion Fatigue–The "Bad Stuff"

Compassion fatigue is the flip side of compassion satisfaction and arises from the negative aspects of helping others. This may arise from unhealthy self-perceptions, stresses of working with colleagues in toxic systems, and work-related trauma. It may be an aspect of burnout, a sense of being overwhelmed and worn out by the helping task and lacking effectiveness.

Burnout

Burnout is an experience of not having enough—not enough energy, time, resources, or successes.

Posttraumatic Stress Disorder and Vicarious Trauma

Another aspect of the compassion fatigue experience can be work-related traumatic stress that can have two aspects. The first is a direct primary traumatic experience by a staff member, such as a violent attack or the death of a child. In such extreme situations a staff member could develop PTSD. The second, more common experience is that of secondary trauma experiences called vicarious trauma or secondary traumatic stress. Vicarious traumatization is a negative change that occurs within those helping others who are trauma survivors (Saakvitne & Pearlman, 1996). Vicarious trauma is about having too much—too much trauma, threat, and feeling overwhelmed and dehumanized.

Workers can be vulnerable to vicarious trauma if they have had a number of adverse childhood experiences or later adult critical incidents and currently lack personal and professional support (Arledge & Wolfson, 2001). This can be heightened by an inability to draw professional life and work boundaries and to care for one's self physically, emotionally, and socially. Conrad (2010) noted that vicarious trauma can negatively affect the workers' sense of trust, safety, control,

self-esteem, and the ability to form close intimate relationships. Vicarious trauma triggers can arise from repeated exposure to the young person's traumatic material and the worker's emotional identification with their service user's experiences. This vicarious trauma can be further heightened by a sense of failing the young person or her or his family and a sense of powerlessness to change the service user's situation or an inability to ask for help (Conrad, 2010).

> Question: Have you noticed in yourself or colleagues the impact of vicarious trauma in any of these areas: trust, safety, power, esteem, or intimacy? What have you experienced or observed?

Trauma Mastery in Child and Youth Care Workers

As part of their compassion fatigue experiences, child and youth care workers may also, like service users, attempt to regain, consciously or unconsciously, trauma mastery by repeating actions and behaviors that have not worked in the past, hoping they will the next time. Such attitudes and behaviors may include the following:

- not taking breaks, feeling indispensible
- constant returning to risky situations
- blaming colleagues or team for failures
- isolating self and forming cliques
- claiming superior skills and knowledge
- not setting professional boundaries
- taking responsibility for things they have no control over
- bullying, harassment
- micromanagement

Other staff may try to avoid any attempt at trauma mastery by physically or emotionally withdrawing from dangerous and previously traumatizing environments.

> Question: What examples of trauma mastery and avoidance have you seen in yourself or other workers?

Staff attempts at trauma mastery are not always recognized and addressed in stress management and self-care workshops and organizational policy and protocols. This often leads such approaches to be ineffective on any long-term basis. Thus, an important part of trauma-aware approaches is helping workers and teams to identify and deal with such destructive dynamics that impact service users, workers, other staff, and the organization.

What is Trauma-Informed Care?

Through the ACE study and current neurobiological research and practice, a whole new focus on trauma-informed care (TIC) is beginning to permeate child and youth care services (Bath, 2015; Fallot, 2011; Hodas, 2012b; Bowie, 2013; Perry, 2014; SAMHSA, 2014).

Fallot and Harris (2006) define trauma-informed care and services the following way: "Human service systems become trauma-informed by thoroughly incorporating, in all aspects of service delivery, an understanding of the prevalence and impact of trauma and the complex paths to healing and recovery. Trauma-informed services are designed specifically to avoid retraumatizing those who come seeking assistance" (p. 3). Fallot and Harris (2009) noted that "Creating cultures of trauma-informed care approach to organizational change is built on five core values of safety, trustworthiness, choice, collaboration, and empowerment" (p. 3). A later SAMHSA publication (2014) added another core value: respecting cultural, historical, and gender aspects of the service user's experience.

Six core principles can be applied to service users in more detail by asking the following questions:

1. **Safety:** How can physical and emotional safety be ensured for service users throughout the human services systems?
2. **Trustworthiness and Transparency:** How can service users' trust in staff and their services be maximized? How can tasks and responsibilities be made clear while maintaining appropriate boundaries?
3. **Peer Support:** How can an environment conducive to the development of mutual support networks of service users or consumers be provided?
4. **Collaboration and Mutuality:** How can collaboration and sharing of power between staff, organizations, and service users be maximized?
5. **Empowerment, Voice, and Choice:** How can service users' empowerment, input, and skill-building be made a key priority? How can real and effective choices for them be ensured?
6. **Culture, History, and Gender:** How can the cultural, historical, and gender aspects of the service users' experiences be respected and integrated?

Bath (2015) condensed these six core principles into safety, connections, and coping with inner turbulence. Fallot and Harris (2009) developed a number of organizational self-assessment tools based on these core principles for service users.

When appropriate, these can be used to develop a more trauma-informed care approach:

- *Trauma-Informed Care Organizational Self-Assessment for Consumer-Run Recovery Organizations* (n.d.)
- *Guide to Completing the Agency Self-Assessment* (n.d.)
- *Trauma-Informed Organizational Self-Assessment for Child Abuse Prevention Agencies* (n.d.)

> Question: What areas in your organization need to be more trauma-informed?

Fallot and Harris (2009) commented, "If an organization can say that its culture reflects each of these values in each contact, physical setting, relationship, and activity and that this culture is evident in the experiences of staff as well as consumers, then the program's culture is trauma-informed" (p. 3). The TIC approach in many ways gives greater understanding of why some helping approaches work and others do not. A "you're broken and we are going to fix you" approach generally does not work, but rather a "what happened" and "how can we help you feel safe" relational approach is more healing.

The benefits of a TIC approach are that it increases safety for all involved with the organization and it improves relationships through a healthier social environment. The TIC approach creates a safe and hopeful workplace culture that also cares for caregivers and in turn improves their success and job satisfaction, which has a positive impact on quality of service, and helps decrease negative encounters and incidents (Sharp & Ligenza, 2012).

Many human service systems still do not regularly and comprehensively inquire about the impact of past and current trauma experienced by service users and staff. Without this knowledge, service providers may make mistakes and have wrong assumptions in the way they respond to and support young people. This may lead unintentionally to the revictimization or retraumatization of those they are trying to help.

Thus, it is best to take a universal precautions approach to trauma in service users' lives with service providers' roles being to respectfully and carefully explore their past and current histories of trauma. Also at the same time it is necessary to ensure that service procedures, protocols, processes, and environments all create a safe, trustworthy, and respectful environment so that service users do not see the service as a source of further distress. Such principles also need to be applied to staff.

Applying TIC Practices to Staff

A key aspect of applying trauma-informed approaches in staff self-care is that of trauma stewardship. Van Dernoot Lipsky and Burk (2009) defined this as "[t]he whole conversation about how we come to do this work, how we are affected by it, and how we make sense and learn from our experiences" (p. 6). They also commented that this involves developing and maintaining "[a] long-term strategy that enables us to remain whole and helpful to others and our surroundings even amid great challenges. To participate in trauma stewardship is to always remember the privilege and sacredness of being called to help" (p. 6).

Pearlman and McKay (2008) recommended asking on a regular basis some key questions at an individual, team, and organizational level that can start such a conversation: "Why am I doing this work? Do I know what I am doing and why? How do I measure success in my work? What can I control and not control at work? What are the costs and rewards of my work? How am I changing?" (p. 30). Such inquiries help staff and management to gain and keep a perspective on what they are doing, why they are doing it, and how it is affecting them.

TIC is built on certain core values, but in practice, many child and youth serving organizations make safety and well-being of service users a higher priority than staff. Fallot and Harris (2011) noted "[w]e have come to see, in the past several years, that the experiences of staff members are equally important in these domains . . . when they experience these factors in their working environment and in their relationships with supervisors, administrators, and colleagues" (p. 31). All these principles are based on creating a sense of safety, security, and predictability for the service users.

Fallot and Harris (2011) recommended that these TIC Core Principles be considered once more but with a focus on the staff. This can be done by asking the following questions:

1. **Safety:** How can physical and emotional safety for staff throughout our human services systems be ensured?
2. **Trustworthiness and Transparency:** How can workers' trust in their fellow staff and their services be maximized? How can tasks and responsibilities be made clear while maintaining appropriate self-care boundaries?
3. **Peer Support:** How can an environment conducive to the development of mutual support networks of staff be provided?
4. **Collaboration and Mutuality:** How can collaboration and sharing of power between staff, their organizations, and service users be maximized?
5. **Empowerment, Voice, and Choice:** How can staff's empowerment, input, and skill-building be made a key priority? How can real and effective choices for them be ensured?
6. **Culture, Historical, and Gender Issues:** How can the cultural, historical, and gender aspects of the service workers' experiences be respected and integrated?

It is key to a trauma-informed care approach to staff and team well-being that each of these core principles be examined in detail, and procedures and protocols be developed at all levels to help ensure and maintain staff wellness. This can be done by adapting some of the organizational self-assessment tools such as those recommended by Volk (2008) for use with staff. If staff members feel that these principles are present in their organization, they will generally have greater passion and commitment to their work and those they serve. Kahn (2005) and Modlin (2012) consider a safe environment as a supportive, holding environment.

The TIC approach is the concept of universal precautions, based on the assumption that clients coming into such services will have histories of trauma. However, such a presumption is not always applied in the employing, training, and support of staff. This is despite the previously mentioned growing research showing relatively high ACE levels of trauma in human service professionals (Black, 2008; Bowie, 2013).

This lack of focus on staff safety can be seen in many current organizational initiatives and staff workshops on stress management, burnout, and vicarious trauma that keep repeating the same old mantra of "change your attitude and habits, resources, or situation." They, however, do not incorporate up-to-date information on trauma-informed care as it relates to staff and so may make little difference to staff stress and traumatization levels. Similarly, Hodas (2012b) noted that "[a]ll too often, the outcome for staff working in an organizational structure that is not trauma-informed is 'burnout' and staff turnover" (p. 2).

Such self-care training approaches can also give the impression that the total responsibility for self-care lies with the workers themselves and often neglects or downplays the equally important role, negative or positive, of the team and organizational climate. In its negative form such attributions may lead workers to take on roles and responsibilities that are not theirs to take or to feel guilty over things they cannot control. These responses may trigger further worker attempts at trauma mastery and create further hopelessness and retraumatization (van Dernoot Lipsky & Burk, 2009; Bloom, 2010).

Reynolds (2011) observed that "[b]urnout sounds like we're toys with disposable batteries that are used up. As if we're not doing enough yoga or drinking enough water, and these are important things . . . but self-care is not enough to offset the issues of poverty, violence, and basic dignity people struggle with. No one advocating self-care suggests that it will create the necessary practical changes in the daily-lived realities of clients" (p. 29).

Such blaming or strengthening interventions focusing on increasing individual staff members' coping skills are the most common strategy used to deal with staff under stress, partially because it is the easiest and cheapest. However, such approaches often prove the least effective. Maslach et al. (2001) emphasized the importance of addressing organizational factors because these exert the strongest influence on staff stress, burnout, and workplace violence (see also Kahn, 2005; Bowie, 2011; Bloom & Farragher, 2013).

So considering trauma-informed care at the individual level, service providers need to be reminded that self-care is not a substitute for comprehensive team and organizational approaches. If it is used as such, often all that is done is rearranging the staff self-care deck chairs on the organizational Titanic. Thus, the issue of team and organizational self-care will be dealt with in more detail in article two (Bloom & Farragher, 2011, 2013).

Developing a Staff Trauma-Informed Self-Care Plan

Volk et al. (2008) offered a self-care assessment tool to show how one is doing in the areas of physical, psychological, emotional, spiritual, workplace, and professional self-care. This self-assessment tool helps identify one's current situation against which one can compare one's progress in self-care. The ProQOL online assessment tool (Stamm, 2010) is also a key resource to gauge how one is functioning and what needs to be managed or changed (Bowie, 2008).

> Question: How did you do with your self-care assessment? Any surprises or things that need to change?

A good place to start with developing a plan is the self-care ABCs of **A**wareness, **B**alance, and **C**onnection (Pearlman & McKay, 2008; Bowie, 2008; CME Resources, 2011). Such strategies should not be new to child and youth care workers and may be a revision of what service providers are already doing or should be doing.

Awareness

Service providers bring their past and present to whatever they do. This includes their beliefs, worldviews, prejudices, biases, social support systems, adverse childhood experiences, illnesses, and family, financial, and social contexts. All this happens within the context of the individuals' internal needs such as safety, significance, self-worth, and success. This also occurs within broader work and social relationships, team, and organizational demands, and the wider sociopolitical context (Stamm, 2010).

The Headington Institute (Pearlman & McKay, 2008) maintain that self-awareness comprises physical, emotional, and relational self-care as well as spiritual self-care. Each should be considered.

Physical self-care involves making time for exercising regularly, having a healthy diet, drinking enough water, using alcohol moderately, and having sufficient sleep. The use of mindfulness and relaxation techniques may also be important, but not everyone finds such passive approaches work for them and prefer more active strategies.

Emotional and relational self-care includes building and nurturing meaningful relationships, not just Facebook friends. It includes not isolating oneself be-

cause of one's work and not having people to talk with. A key aspect of this is having a support group of friends and colleagues. An effective support group can provide those who can challenge one, give emotional support, supply how-to-do-it information, and supervise and mentor one. Many workers don't have such a support group, or if they do, it may be comprised of only a few people. In such a situation the worker needs to find a support group or set about creating one. This is not an easy task if one is already feeling tired and burned out. One should start earlier rather than too late. It is also key to have good supervision and external mentoring, and counseling if needed.

> Question: How good is your support group? What needs to be changed or developed?

Having time to stop, reflect, meditate, or journal are important for self-renewal. Also helpful is enjoying creative activities that absorb one's here-and-now attention and that quiet the internal mind's chatter. It is important for workers to monitor and limit the amount of trauma material they are exposed to through the various forms of media, and to cultivate a sense of hope and humor. It is key to understand the impact of stress and trauma on oneself and others (Skinner & Roach, 2005; Pearlman & McKay, 2008; Volk et al., 2008; Bloom, 2010).

Spiritual self-care is also an important but often neglected or downplayed aspect of self-care. This includes identifying one's core values and knowing who or what motivates and inspires one. Music, singing, and being in nature can all be part of one's spiritual self-care. Regular times of meditation and prayer within a faith community can be important. Being passionate about these things can be helpful (Auw, 1991; Pearlman & McKay, 2008; Palmer, 2009). The Maori approach to wellness (Durie, 1992; Bowen, 2014) includes family health, psychological health, physical health, and spiritual health. Spiritual health focuses on the source of hope for a person. Hopelessness is one of the products of having a significant ACE score and can result in child and youth care workers becoming jaded or apathetic.

Balance

Balance and self-care involve having the right priorities and expectations about staff work and personal life. One needs appropriate limits and balances. Multitasking and working extended hours do not improve workers' effectiveness. Sometimes by doing less, one may achieve more. One should take regular breaks away from one's desk and service users and schedule uninterrupted time to relax and think.

Connection

Possibly the greatest growing challenge to the balance of work and life is our constant online connection through electronic media such as emails, phones, and

texts. One is constantly faced with a sense of urgency rather than what is most important. Staff may dread coming back from holidays because there are so many emails to deal with, if they have not already checked them while on a break. One needs to be able to digitally detox and create times of solitude in order to be more resilient and effective. In some extreme cases workers can become addicted to stress (May, 1991; van Dernoot Lipsky & Burk, 2009).

Connection and self-care involves connecting with friends, peers, and various support groups and communities. Such support enables workers to enhance their social and emotional well-being and improve their skills to perform their required work tasks. Support can come from family, friends, work colleagues, and managers and supervisors (Workforce Development NCETA, 2005). Connecting with an external mentor can help staff look at wider issues relating to their whole lives and not just their work, thus helping them to gain a sense of objectivity.

> Question: So what do you now need to add, subtract, or modify in your own TIC self-care plan in the physical, emotional, relational, and spiritual areas?

A Final Note of Caution

Organizations will face significant roadblocks in supporting self-care plans for staff due to employment laws in some countries which mandate that health and mental health concerns not be included in personnel decisions regarding hiring, promoting, retaining, disciplining, and termination of employment. Working within this framework of supporting staff legally must be a commitment to support them emotionally and psychologically to withstand and ultimately prevail over the trauma that pervades the social service system.

Conclusion

This article has drawn on current research in the areas of adverse childhood experiences, trauma-informed care and services, and trauma stewardship to help workers develop a long lasting, effective trauma-informed self-care plan. It also has drawn on theory and practice from resilience approaches as well as The Sanctuary model. However, as previously noted, staff self-care plans will ultimately be ineffective if they are not formulated within the broader staff and organizational context.

The second half of this article in a future edition of this journal will examine more closely the organizational context of workplace trauma. This organizational context, including management style, can often be toxic and trauma-provoking within the workplace itself, impacting on managers, staff, and those using the service. However, this does not necessarily always need to be the case if the principles for trauma-informed care and services outlined in the article are modified and implemented at organizational and societal levels.

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TOWARDS TRAUMA-BASED CARE: ERIKSONIAN PERSPECTIVES ON CHILD AND YOUTH DEVELOPMENT IN THE 21ST CENTURY: A COLLECTION OF PERSPECTIVES

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Erik Erikson has been a part of our child and youth work intellectual heritage for decades. His famous life course theory, "Eight Stages of Man," with key developmental themes assigned to identifiable stages influenced how we view child and youth development and development throughout the life course. Terms like industry and identity reshaped our vocabularies and our thinking. Perhaps most important, Erikson's theory provided invaluable insights as to how healthy development should proceed and what kinds of interpersonal and environmental experiences could either promote or impede it.

Much has transformed in society and in the process of development since Erikson's initial formulation in 1950. These changes, along with advances in developmental psychology, make it timely to reassess these well-known themes and their applications to the developmental challenges facing youngsters in this twenty-first century. One of the major challenges is how to properly treat the ever-increasing number of children and youth who have experienced trauma. Violence, abuse, neglect, warfare, and natural disasters are examples of shattering experiences that children and youth who come into care have experienced.

Fortunately, the concept of trauma-based care has emerged, with a focus on providing treatments and experiences that directly address the outcomes of having experienced trauma. A revisiting of Erikson can illuminate for us how the major tasks and themes of development can, if supported by trauma-based care practices, contribute towards reversing the damage and put youngsters on a positive developmental path towards adulthood.

The purpose of this special collection of papers on Erikson thus is to remind us how Eriksonian theory and concepts apply to children, youth, and young adults today, and to update Erikson's ideas themselves and come to an understanding of the contemporary contexts and processes of child and youth development. In that way we honor Erikson for his brilliance and insights so that rather than having his theory slip into disuse, it can continue to illuminate our field and practice for many more years. Erikson's notions of basic trust, autonomy, mastery, industry, and identity still relate to understanding the traumatic experiences affecting children and youth today and should help them overcome their traumatic pasts. Promoting resilience is one way to set young people on a positive path to a better future, no mat-

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ter what the past, and Erikson's thinking, both past and updated, is relevant to this.

This collection consists of three papers. In the first, "Is It Still Industry: A New Look At Erikson's Relevance to School Age Youth with Implications for Practice," Karen VanderVen looks at the concept of industry as characterizing the school-age years, using her own newly developed criteria for reexamining Eriksonian theory. Industry is still important, but there are other important issues for school-age children to deal with as well. Moving upwards in the developmental progression, in "Erikson and Adolescent Development: Contemporary Views on an Enduring Legacy," Matthew Bundick and Peter Benson bring new perspectives to the concept of identity that Erikson had linked to adolescence. They show how Erikson, contrary to common belief, recognized identity's complexity. The authors point out how the concept of psychosocial moratorium relates to the current strengths-based approaches to development, such as the Search Institute's well-known Developmental Assets Framework.

Completing the trilogy is "Erikson's Young Adulthood and Emerging Adulthood Today," by Marilyn J. Montgomery and Jeffrey Jensen Arnett. The concept of emerging adulthood has been one of the most widely recognized advances in developmental theory, and as the authors point out, young adulthood in society today, and the tasks associated with it, have changed a great deal since the 1950s. Child and youth workers will find this piece enlightening because it explains where children and youth may be going developmentally. It will enhance the workers' self-understanding that is such an important part of child and youth work and necessary as they help children deal with any traumatic experiences they have experienced.

IS IT STILL INDUSTRY? TOWARDS A NEW LOOK AT ERIKSON'S RELEVANCE TO SCHOOL AGE YOUTH WITH IMPLICATIONS FOR PRACTICE

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Step into an urban after-school program. In one area, two youngsters are busily constructing a robot with Legos, with printed instructions laid out in front of them. In a corner, three giggling girls are glancing at another girl, who looks uncertainly around her. They focus on a knot of boys who are nudging each other and continue giggling. A boy tries to join the Lego group, but soon turns away. He wanders into the gymnasium where a basketball game is just being organized. In the homework corner, several youngsters grumble as they open their math textbooks and take out their worksheets under the watchful eye of a staff member.

The vignette above contains a hint of the complex issues and behaviors characterizing school age youth today. Much has changed since the post-World War II years in which Erikson wrote, including the development of after school programs. In 1950, in his famous book, *Childhood and Society* (1950), Erik Erikson proposed his eight stages of development, suggesting that the positive outcome for successfully negotiating the school age years was to develop a sense of industry: With the oncoming latency period, the normally advanced child . . . now learns to win recognition by producing things . . . he comes ready to apply himself to given skills and tasks . . . He develops *industry*—that is, he adjusts himself to the inorganic laws of the tool world. He can become an eager and absorbed unit of a productive situation . . . The work principle (Ives Hendrick) teaches him the pleasure of work completion by steady attention and persevering diligence.

His danger, at this stage, lies in a sense of inadequacy and inferiority. If he despairs of his tools and skills or of his status among his tool partners . . . he abandons hope for the ability to identify early with others who apply themselves to the tool world . . . and considers himself doomed to mediocrity . . . Many a child's development is disrupted when family life may not have prepared him for school life or when school life may fail to sustain the promises of the early stages (226–227).

This is the negative resolution of the "psychosocial crisis" (1050) or "antipathic counterpart" (Erikson, 1982, p. 64). With Erikson's primary description of the psychological tasks of the school years reviewed, one can ask, "How would this apply today?"

The purpose of this paper, therefore, is to reexamine Erikson's concept of development during the school years and of changes in social context and advances in developmental theory that inform and shape the new formulations. A special attempt is made to situate and reinterpret them as closely as possible in an Eriksonian conceptual framework—in other words, applying Erikson to himself as much as possible.

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The paper includes the following:

- Citation of key changes in society that particularly impact school age children
- Review of advances in knowledge of development and theoretical conceptualizations of the life course
- Description of some key features of a contemporary life course theory that will characterize the reformulation of Erikson's original description of the school-age years
- Presentation of a proposed new model of development in the school-age years in an Eriksonian vein
- Implications of the new theory for current practice issues

Trends in Society and Developmental Theory

Societal Trends

Eriksonian theory established solidly the power of sociocultural context in shaping the process and content of development. Thus if this context has changed, and there is no doubt that it has—radically—, then in a transactional way changes must be made to Eriksonian theory to reflect these changes. Given that, Erikson's initial eight stages of human development were situated in the post-World War II context of the late 1940s and early 1950s. To optimally consider any application of Erikson today, one must consider that the practices and values of society have changed.

With some danger of oversimplification, there are salient characteristics of society today that have exerted a powerful influence on child and youth development since Erikson's proposals and today might be deemed particularly relevant to understanding the school-age years (VanderVen, 1996).

Many of them concern the nature of the activities that occupy school-age children, which could affect the degree to which youngsters develop the tool skills described in the following section by Erikson.

Characteristics of Society

Technology. The advent of technology has had a transformational effect on child and youth development. Computers, cell phones, email, search engines, video games, and social networking sites—are all used, often quite competently, by today's tech-savvy school-age children. However, despite the emergence of potentially developmentally adaptive activity afforded by these technological advances, such as interactive games and online collaborative learning environments, there are forces that mitigate making optimal use of them. These will be addressed later in this article.

Over-scheduling. Eccles et al. (2006) counter an earlier contention that children are harmed by participation in too many adult-directed, structured activities because they do not have time for relaxation and independent play and exploration. Actually, overscheduling is a social-class related phenomenon, where it is much more applicable to upper-class children. Lower-class children are much less likely to have access to these kinds of activities, to their detriment (Lareau, 2003). However, when taken to the extreme, as it often is in sports, overscheduling can have negative effects such as stress.

Premature maturity. This concept suggests that the standards of maturity, in terms of worldliness, sexual interest, and teenage clothing—most particularly for girls—is steadily creeping downwards from adolescence into the elementary school-age years. Among a host of other dangers that accompany a sense that children should dress, think, and act older than their age, one vital concern is that these improperly advanced interests deter girls from developing the skills and activity involvements that formerly characterized the elementary school years and indeed Erikson's stage of industry.

The self-esteem movement. This is "defined by how much value people place on themselves" (Baumeister et al., 2002, p. 2). Perhaps misinterpreted, but certainly misapplied, the pressure to ensure that children always feel good about themselves that took place in the 1980s, like so many other well-intentioned movements, came to have unanticipated—and damaging—results. These include diminished motivation and decreased care in work habits. Ironically, and sadly, there is evidence that this overemphasis on self-esteem has led to a possible decrease in real self-esteem, when that is defined as real achievement acknowledged by others (e.g., VanderVen, 2008).

Decline of neighborhood safety. In the past, youngsters in most neighborhoods could safely roam about, with adults informally watching out for them and with bullying from others perhaps occurring but not as intensely as it does today. Increase of gang behavior and unsafe neighborhoods, particularly in urban centers but also in suburbia, are a pressing issue today and represent a real threat to optimal development in childhood.

Emergence of after-school programming as a societal institution. In 1950, after-school formal programs were almost unheard of. Youngsters would typically go home after school and go out and play. There was much less formally organized activity than there is today for the segment of the population of children (upper middle- and upper-class) who now more consistently receive such activities. Access to the kinds of activities that contribute to acquisition of both academic and life skills during the school-age years is more limited for lower-class children whose families' life styles and incomes do not always enable these opportunities (e.g., Lareau, 2003). Due in part to the increased number of mothers into the workforce, after school programs have become one of the fastest growing forms of children's services today.

Elimination of recess, music, physical education, and the creative arts in many schools. Both budgetary problems and changes in values and practices in schooling have resulted in greater attention to—indeed, a near exclusive—focus on basic academic instruction. These practices fly in the face of recognizing such contributors to learning as social skills, engagement, physical fitness, and the opportunity to be exposed to areas in which one might discover a special talent. For those children for whom academic learning, for whatever reason, is a challenge, developing and having others recognize nonacademic areas of strength is crucial for their positive development. Furthermore, where the school does not offer a varied palette of activities, singular emphasis on core subject knowledge may serve to decrease motivation to learn, in that the children simply will not like school or enjoy going to school.

Changes in family structures. The decline of the stable nuclear family is well-documented. Today there are numerous family structures: single-parent households, same-sex parents, and so forth. A much greater percentage of women are employed full time outside the home than were in 1950. In part as a response to these changes, interventions for children are much more family centered and focused on the total environment of children, that is, a holistic or ecological approach as pioneered by Urie Bronfenbrenner (1977), with his famous concept of embedded systems that contain and influence the development of children.

Increase in social and emotional problems in childhood settings. Behavioral problems seem to be on the increase, ranging from bullying to attention deficit disorder, to resistance to adult authority. In particular, bullying—ranging from teasing to excluding to violent behavior—is a profound concern today to the extent its origins, as well as manifestations, are not yet fully understood, and in the case of the consequences for bullies and their victims, can be severe.

Trends in Developmental Psychology

In developmental psychology, many changes, conceptual and empirical, have occurred since 1950 that advance our understanding of both theoretical approaches to child development and the actual nature of the developmental process. While all of these cannot be reviewed or covered here, the following are the most salient.

Decline of psychoanalytic theory. Erikson was a psychoanalyst primarily, and his theory moved psychoanalytic theory to new levels of comprehensiveness and relevance. Subsequent to the high value of psychoanalytic theory in the 1950s, an influx of new ways of approaching development emerged, including behaviorism, positive psychology, social cognition, and postmodernism. Incorporating aspects of more recent theories holds the promise of enriching and making Eriksonian theory more applicable while still remaining faithful to its psychoanalytic roots.

Nonlinear dynamical systems theory. Nonlinear dynamical systems theory, concerned with interconnectedness, unpredictability, and disequilibrium in systems, has been applied to development and developmental concepts, and has rapidly

transformed thinking about it. Indeed, that is in great contrast to the premise that "Models of developmental change assume an orderly, sequential, and predetermined unfolding of psychological functions and structures" (Galatzer-Levy, 2004, p. 419). Analyses of applications specific to Erikson have been done by Galatzer-Levy (2003) and VanderVen (2005). According to the former, Erikson proposed a "basic psychoanalytic model, [with] the assumption of developmental sequences with development described as occurring in an orderly series of steps roughly tied to a person's age" (p. 421). However, "Nonlinear dynamics suggest that development can occur by other means than epigenetic unfolding of predetermined developmental lines" (p. 423). Another interpretation of epigenesis and Erikson's life cycle theory suggests that development is more nonlinear and complex than is commonly thought. But in the sense of nonlinear dynamical systems theory, as it is considered in-depth by Galatzer-Levy, Erikson's formulation is not sufficiently complex, given current understanding of both the theory and of the developmental process.

Resilience and positive psychology. Emerging from the emphasis on pathology that once dominated developmental psychology and was encouraged by psychoanalysis is a focus on the qualities that make children thrive even in the face of adversity. This perspective focuses more on strengths and how difficulties help youngsters develop positive strategies for dealing with difficulties. Recent work on developmental assets reflects this approach. Developmental assets are those ingredients or "building blocks for success, both in the external environment and internal developmental processes that contribute to making a young person psychologically strong" (e.g., Scales, Sesma & Bolstrom, 2004; VanderVen, 2008). Among recognized indicators of resilience are involvement in activities, hobbies, and positive attention from nonfamilial adults (Werner & Smith, 1992). There are many other strengths highlighted within the study of positive youth development, such as optimism, autonomy, and the presence of social support. However, not all positive psychological notions are associated with positive development under all circumstances. As discussed earlier, an overemphasis on self-esteem can lead to undesirable outcomes. Positive self-esteem comes from accomplishment over time that is deserving of respect from others.

Change and Stability in Eriksonian Theory

Subsequent to Erikson's proposal for the eight stages of development, numerous scholars of the life cycle proposed some new ways of viewing it. Perhaps the most evident among these changes is that the name has changed from *life cycle to life span* to the current *life course.* Two conditions are needed to make Erikson relevant today:

1. Recognizing that his work has often been misinterpreted in a simplistic way, meaning that certain critiques may not really apply. For example, Erikson's original life cycle theory has too often been rigidly tied into

"stages" and their associated developmental outcomes too tightly bound. A careful reading of Erikson shows that these criticisms are inappropriate. He describes how a succeeding stage unfolds and emerges from the previous ones, and that such qualities as identity not only begin earlier than adolescence, but also may remerge later on in life. Indeed, it is true that Eriksonian life cycle theory can be interpreted as more complex and dynamic than these reductionist interpretations even though, as just described, it as not as complex as suggested by current nonlinear dynamical systems theory applied to development.

2. To revise or adapt Eriksonian theory in such a way that the result, paradoxically, reflects necessary changes to make it fit better to these contemporary conditions while incorporating as much as possible the many Eriksonian ideas and concepts that are almost timeless in their relevance. In a sense we do not want to throw the baby out with the bath water.

Implications for Theory Revision and Modification

There are numerous implications of the above considerations that properly integrated would entail the formulation of an overhauled, if not entirely new, Erikson-inspired theory of development in the school-age years. While these implications are not all enumerated here, some of the most important among them include the following:

- Greater emphasis or inclusion of needs for safety, both emotional and physical
- Need for greater adult attentiveness in general and monitoring of children's activities, including advocating for health activities that have been downsized in recent years and assuring that violent, aggressive, and exclusionary behavior is addressed
- Focus on providing the activities of childhood that expose youngsters both to the intergenerationally and peer transmitted culture of childhood and to the authentic and authoritative domains that nurture academic skills and interests, engagement, knowledge, and identifiable, useful skills
- Inclusion of ways of providing appropriate adult caring and empathic emotional support

Basic Features of a New Model

The new model for Erikson's Stage of Industry vs. Inferiority will contain the following features:

Phases rather than stages of development. Throughout his writings, Erikson refers to stages of development, and he is generally referred to as a stage theorist. However, Levine (1989), in her review of adult development theories, considers Erikson's

to be a phase theory. According to Levine, a phase theory focuses on "the major life tasks or conflicts that stimulate growth. These tasks or conflicts emerge at relatively specific times in the life cycle. The way we accomplish or resolve them continues to influence us for the rest of our lives" (p. 61). This concept is more akin to what most developmentalists feel are stage theories. Combining Levine's thinking and the more recent perspective that development is less defined by a specific theme tightly linked to a specific age, the term *phase* reflects the inexact boundaries of the beginning and termination be associated with the general age range.

Themes of development not bounded by stages. A theme is a developmental feature or task that can be associated with a particular phase, but may be associated with others and is not rigidly bounded in concept. For example, *identity* is not a singular concept. It has been described in extensive literature as having many different types, manifestations, and forms of presence across the entire life course.

Greater complexity of the developmental process—non-linear and recursive aspects. This is concerned with the notion that one major developmental theme, even if it contains all aspects of those that preceded it, is too simplistic and that modern insights into nonlinear dynamical systems theory encourage a multicomponent picture. Nonlinear dynamical systems theory, also known as chaos or complexity theory, has been applied to human development for many years. As to Erikson, on one hand (as stated earlier) his theory does not propose the invariant, rigid progression of age related stages many who misread him claim it to be. On the other hand, his theory does not incorporate the degree of complexity necessary to fully explain such an inherently complex phenomenon as human development.

Viewing stage related themes as universals throughout the human life course. Erikson's universal themes of development, for example, trust, autonomy, initiative, industry, identity, and generativity, are present in all recognized phases of development to a more or less salient degree—as, often little recognized by others, which was acknowledged by Erikson. If some (erroneously) consider Erikson's theory horizontal with its stages, they can also be considered vertical—a common theme throughout the life course, although manifesting itself in different ways at various ages. Anna Freud's concept of "Developmental Lines" (1965) stressing how important developmental themes evolve over time to greater maturity, comes to mind. Combining the notion of developmental lines with Erikson's age-related themes could have great promise in that it would enable a more graphic and obvious representation of Erikson's own recognition that these universals are present in various manifestations throughout life, taking a more organizing stance at one particular age range.

Dimensions rather than dichotomies. Development is so complex that viewing any attribute as located at one or the other pole of a dichotomy is not an accurate representation. We are on safer ground if we consider any theme or characteristic as distributed along a dimension of more or less rather than absolutely present or absent. The concept of "masculinity" and "femininity" are good examples.

Multiple themes with varied emphasis. A new theory may propose being selective in both the emphasis on a particular theme or phase, including or excluding certain ones, and attending to any particular ones of these more than others, as is indicated by the particular context. For example, in a reworking of adolescence, the *theme* identity could still be salient—but perhaps be not the only theme, and perhaps not have the same sole emphasis.

Changed and added developmental themes. Since both society and developmental knowledge have changed, it is not surprising nor inappropriate to propose that there may be new concepts to add to Erikson's theory or key concepts that require modification. This is particularly applicable when considering the early childhood years. For example, the notion of self-regulation of emotion and resultant behavior has become the focus of much attention—and, given the prevalence of their inadequate development, the source of serious concern in recent years (e.g. VanderVen, 2008). An enhanced understanding of how they operate in childhood invites a re-evaluation of Erikson's emphasis on autonomy and initiative.

The Revised Eriksonian-Based Model for Development in the School-Age Years

The Eriksonian conception of the developmental meaning of the school-age years within Erikson's work itself . . . almost. Integrating the themes leads to a contemporary model that sustains Eriksonian structures and concepts.

Adding complexity and continuity, the model will include developmental themes at three different levels: primary, supportive, and contextual. A primary theme follows Erikson and posits that the particular phase of development can be expressed with a unitary construct. A supportive theme is one that contributes to the attainment of the primary theme, allowing it, even though unitary, to be in fact more complex, composed of multiple aspects. A contextual theme is one that was originally proposed by Erikson as a central task of a particular stage but recognized by him as being dealt with and developed in its own appropriate way in other stages. And therefore, while the primary theme and the supportive themes will be discussed explicitly. The contextual theme will be discussed in relation to other subthemes.

The Primary Theme of the School Years: Competence

Rather than maintain industry as the primary task of the school years, competence, following the influential work of Ann Masten and Douglas Coatsworth (1998) among others, is proposed. In his discussion of industry in *The Life Cycle Revisited*, Erikson himself lists competence as the "virtue" and "primary strength" of this period. Erikson's addition of these virtues as the outcomes of the original eight stages of development, demonstrates a broadening and deepening over time. In one of his last discussions of his life cycle theory, as it was called then (Erikson, 1982), industry was described as "competent mastery necessary to be experienced during the school years" (Erikson, 1982, p. 6).

One might ask, "Why change competence for industry?" The reply is that, in light of the advanced understanding of developmental capacities ushered in by the last half century, a refined definition of industry is now needed. Competence is a more embracing concept than *industry*—significant as that attribute is. The term is current in today's developmental psychology literature. Competence means that a child is developing instrumental skill sets from both academic and multiple domains of childhood activities through a process of authoritative adult instruction, scaffolding, and experimentation. Both are crucial. Competence also means that the youngster is developing important social and emotional attributes necessary for functioning in the adolescent and adult world to follow. In these ways, competence is holistic and multidimensional, in accordance with the aforementioned principle of nonlinear dynamical systems theory.

The significance of competence is further highlighted by Eccles and Wigfield (2002), who call the human "basic needs for competence" (p. 112). Masten and Coatsworth (1998) suggest that being competent does not mean that the child is always happy, has a high self-esteem, and is without problems and issues. Thus a resilience rationale for the competence phase is central. Youngsters must be resilient with sufficient core of self as expressed in specific interests in what they are engaged in, along with the requisite developing skills needed for participation, to prepare for the demands of the succeeding phase. Thus it is proposed that competence be the focal developmental theme for the school-age years, as well as a significant supportive theme for all the phases of development throughout the life course.

Competence, as conceived herein, is crucial for successful emergence and transition into the next developmental phase, as proposed by VanderVen (2006): the middle school years. Given the incredible demands and normative temptations of that phase (e.g., puberty, the pressing desire for social acceptance, peer influence to engage in unhealthy or risky practices), as the child leaves the relative security of the elementary school years, a strong consolidation of the emotional, social, and behavioral strengths (along with activity and academic skills) that mark fully developed competence is needed.

Supportive Themes

Industry. Industry interestingly remains a crucial quality of the childhood period in general, from toddlerhood through adolescence and on into adulthood. Self-regulation, the salient task of the preschool years, pertains to a variety of attributes that enable a youngster to display self-control in the face of frustration and temptation. However, the notion of self-regulation seems to be less tied to task and learning performance than to emotional constraint and interactions with others in daily life.

Some early childhood educators such as Lilian Katz (1993) have considered the importance of developing dispositions related to work habits in early childhood, as a precursor to school readiness. Such habits include finishing what one

has started, concentrating on a particular activity, and respecting boundaries inherent in the activity. Industry, like so many other Eriksonian concepts, should be considered a life long attribute, although its foundations begin in childhood. Indeed, the groundwork for industry is laid even before the school-age years, as suggested by the development of Katz's work habits or dispositions in the preschool years as necessary underpinnings of successful learning in the school-age child.

Following the understanding of the dynamics of resilience, (e.g., Masten & Coatsworth, 1998) today the main developmental task of the school-age years should be viewed through the contribution of industrious behavior, that is, work habits and approaches to tasks, coupled with emotional self-regulation. This displays and supports competence. Erikson's original theme, in this context, relates more specifically to work habits, that is, behaviors as simple as reviewing and correcting work, evaluating a job to be sure it is done well and all components are completed, and getting underway in an energetic and planful way when there is a job to be done. This theme is a continuation of the notion of work habits, or dispositions in early childhood. For young children, dispositions or habits of mind include curiosity, intentionality, self-sufficiency, and the ability to self-organize. The self-esteem movement did not help with the development of work habits, in that shoddy work and minimal effort would come to be praised, thereby stopping attempts to improve one's approach to the task.

Engagement. Engagement, as presently conceived, is the mental energy necessary to become interested in and involved in the constructive tasks and activities that lead to competence. While engagement is often discussed with reference to adolescents in school (e.g., Bundick, 2011), this quality also applies to school-age children. Engagement is quite akin to the concept of dispositions mentioned before (Helm & Katz, 2001). The relationship of engagement to industry is strong in that engagement in a defined and structured activity serves to promote industrious behavior.

Empathy. Empathy is the ability to recognize that others have feelings and sensitivities and affects the way one treats others. Empathy begins to develop in early childhood, a process which can be disrupted if there are difficulties in forming secure attachments. Empathy is a requirement for making and keeping friends, and given the importance of the peer group to school-age children who are taking the huge step from the family to the world of others, its significance is crucial. Those who have a strong capacity for empathy are more likely to engage in altruistic behavior and less likely to engage in bullying behavior. In fact, it has been proposed that the upsurge in bullying behavior has origins in disruptions in early attachment.

Self-Regulation. Self-regulation, the ability to control and modify oneself without suppressing one's own emotions, figures largely in the potential of school-age children for success. In recent years, as already mentioned, the concept of self-regulation has attained salience in the early childhood community with the recognition that to be prepared for school, preschool children must be able to control

their emotions and behavior. Self-regulation includes the ability to recognize the emotions one is experiencing and includes the capacities to pay attention, solve social problems harmoniously, and to tolerate frustration without a strong behavioral response that requires external intervention.

In line with the intent to connect phases of development vertically, with flexible boundaries and transitions, self-regulation is viewed as a process beginning in earliest childhood with growing significance in the preschool skills and with high importance in the school years. It might be seen as a contributing and supportive factor in Erikson's industry, and ultimately, competence.

Developmental Trajectories. Anna Freud's still viable proposals of developmental lines–crucial tasks in specific domains that change or are "gradated" as a function of growth (Freud, 1965, p. 63) are applicable to this revision of Erikson's proposals on school age children. Making an adaptation based on the more current notion of developmental trajectories, the proposal here is to consider Erikson's universal developmental themes that are so well known, as development trajectories somewhat akin to Freud's developmental lines. They are also still considered current, although other developmental concepts such as those described as supportive themes are more recent and more directly tied into the particular phase of development. For the purposes of this model, the Eriksonian themes of identity and generativity will be considered.

Identity. Perhaps the most fundamental of all of Erikson's constructs, one must go beyond the association of identity with adolescence to acknowledge Erikson's own contention that identity formation begins early in life and continues throughout. For school-age youngsters preparing for middle school and adolescence, with the focus on developing competence, the relationship with identity is obvious. Their own awareness of what, when, and how they are acquiring new knowledge and skills that are of meaning and use in larger society, and also their content of these interests, will shape their growing and emerging sense of self, that is, their identity.

Generativity. The Eriksonian notion of generativity, essentially giving—and giving back—with a particular focus on leaving something positive behind for future generations, has a contemporary meaning important in the development of school-age children. If empathy is a newer indicator of positive development, then generativity is an underlying dynamic. Where school-age youth learn that there are ways that they can serve or give to others, and in a way that is meaningful (that is, makes a lasting impact), this not only encourages the further development of empathy, but also contributes to an overall sense of competence. Helping an older person, looking out for a younger child, teaching a skill to a younger child, caring for a pet, saving money to make a contribution—these are examples of how a school-age youth can be generative. One may not immediately see how such interactions may leave an identifiable legacy, but further thinking can indicate how it can occur. A simple action or interaction, bearing in mind the nonlinear dynamical

systems concept of "sensitive dependence on initial conditions," a small action can have large effects over time. Of course school-age children can perform concrete tasks that leave something positive behind—a sustainable project such as a mural, to give one example. Also, the developmental groundwork of generativity (and development of competence) in the early years can contribute to the sense, when one is elderly, that one has lived one's life in a way that will benefit future generations.

Counterpart Theme: Ineptness

To follow the intent of representing the challenges and themes of school-age child development today in as much an Eriksonian vein as possible, one must consider the developmentally less favorable counterpart to the developmental themes. Perhaps the main characteristic of ineptness is an inability to fit in in some way—that is, to apply the supportive themes and the dynamic interactions between them to somehow become competent as described. When youth have a sense of being inept at whatever activity or life domain in which they are participating, that feeling may become internalized. The degree to which this occurs might vary with the degree of ineptness, the significance of and meaning to, the youth of this particular area, and the context, for instance, the degree to which it is valued. It should be stressed here that some sense of ineptness is not completely negative or a detriment to development—that one learns from one's failures or difficulties, as well as from one's successes and areas of comfort. Such learning can be a stimulus towards greater effort, developing new interests, and other positive outcomes.

Subthemes

To avoid misunderstanding, because the themes described below are not directly supportive of positive development as are those for competence, they will be referred to as subthemes of ineptness. This label was chosen to indicate some of the secondary (albeit still important) outcomes of ineptness in the tasks of competence. These are presented in ascending order of developmental seriousness, that is, the degree to which they are a negative consequence.

Discouragement. When youth are not able to marshal the developmental attributes into the learning and social world of the school years, inevitably they receive feedback. Feeling discouraged does not always bode poorly for overall development, if the youth are lucky enough to have supportive adults and other contextual factors available, who can encourage them in a variety of ways to accept themselves, both strengths and weaknesses, despite the failure, to try again, to practice the requisite skills, and to recognize and develop other areas for knowledge and skill development.

Withdrawal. Withdrawal is in a sense a counterpart of engagement. When an overall sense of ineptness is experienced, in the absence of supports and alternative sources for a sense of competence, the greater danger is in withdrawal. In such a situation, that the youth withdraws their emotional energy and interest, without

refocusing and investing it into something else where they perhaps may have a greater chance at success.

Sadness. With continued input into a growing sense of ineptness, withdrawal may slide into sadness, a more pervasive effect than discouragement or withdrawal, and with more serious implications. With this deep negative feeling, there is less likelihood that without a careful assessment, planned intervention, and monitoring for effective results, that the youth will emerge from the phase of competence and ineptness emotionally unscathed.

Anger. While there is a danger of oversimplifying, a negative counterpart of a sense of ineptness can be anger. As with many emotions, all anger is not destructive: It can be justifiable and can goad its holder into constructive action. At the same time, unsupportive responses of others to ineptness create resentment and anger, and may contribute to the emergence of bullying behavior or other kinds of acting out.

Implications for Practice

How then might this model be translated into specific practices in the various settings holding school-age youngsters? Following are some general and brief considerations:

Schools. In order not only to promote academic competence but also to promote overall developmental competence, along with the areas that support it, schools need to ensure a comprehensive approach to educating the whole child. Indeed the main responsibility of schools is to develop academic knowledge and skills. However, teachers, school leaders, and educational policy makers need to realize that the amputation of activities and pedagogies that provide opportunities for both faculty and students to interact informally, may have a paradoxical and decidedly undesirable outcome. Rather than developing academic competence and fostering academic achievement, there is a risk of lowering it by increasing disengagement, making youth feel there is nothing in school they can attach to, and increasing asocial behavior. Schools must be places where everybody feels safe, both physically and emotionally, devoid of the threat of bullying. Such a school culture and total program would provide opportunity for joint collaboration in meaningful projects such as community service, and opportunity for all youth to discover areas in which they have the potential to develop competence. For teachers and administrators in schools to maintain discipline does not mean that they cannot be relational within their primary intent as educators. Being relational provides a context for positive relationships, characterized by the attention, interest, and encouragement that school-age children need to thrive academically, socially, and emotionally.

After School. It is the special province of after-school programs to provide experience in the domains of activity that for generations have appropriately occupied out-of-school time. These include arts, crafts, games, sports, drama, music,

and movement. More contemporary forms are also appropriate, such as computer skills, video production, and robotics. It is crucial that after-school programs provide truly authoritative and authentic activities. These are knowledge- and skill-based, and play a fundamental role in developing competence, industry, and engagement.

After-school programs also enable staff to provide essential relational ingredients that help develop empathy and prosocial skills. While school teachers can and should be relational, the somewhat more informal context of after-school programs enables staff to be more flexible, informal, and personal within appropriate developmental boundaries. Homework has a place in after-school programs especially for older children whose homework loads are often heavy, but only when properly handled and offered not to the exclusion of rich activity programs. These can support those children who need special assistance with their academic work. Some children will want to do it, some will need to do it, and all should have the option to choose. At the same time, homework must not be a mere extension of the academic school day and should not replace the primary focus on activities.

Families. Of course all families, no matter what their structure, need to provide a fundamentally caring, stimulating, and nurturing environment with sound parenting and caregiving practices. The focus should be less on happiness (e.g., Gottlieb, 2001) and self-esteem, and more on those practices that contribute to the development of competence, self-regulation (industry), and engagement. This is a tremendous challenge in this age where there seem to be more helicopter and absent parents rather than authoritative parents, reflecting back to Baumrind's (1967) important research on effective parenting. Authoritative parents offer crucial attachment figures, stability, and support while simultaneously encouraging their children to develop discipline, to strive for what they want rather than have it given to them without effort while differentiating between wants and needs, which of course should be met.

Conclusion

The significance of a positive outcome of the school-age years cannot be overemphasized. If there is a positive consolidation of the themes already described, one can hypothesize that youth will enter the challenging middle school years with ego strength—which was Erikson's quite appropriate term to refer to a strong consolidation of skills and outlook. The youth must have sufficiently developed interests and skills in the activity world to be able to find a place among their peers, and to resist the unhealthy temptations of premature sexual behavior and substance consumption that can serve as a developmental derailment. To prevent slippage into an exclusionary and bullying mode of behavior, youth must bring up from the preceding phases of development an empathic ability that can provide both the strength to resist peer pressure to mistreat and reject others, and instead help to channel the youth's energy toward positive forms of belonging and prosocial behavior.

In his brilliance, Erikson himself anticipated the movement towards competence as he himself moved beyond Industry vs. Inferiority with the "psychosocial strength" (Erikson, 1964, 1982) of competence, superseding the seemingly dichotomous themes and emerging as a positive outcome of the school years. Erikson had described competence as a virtue: "Competence, then, is the free exercise of dexterity and intelligence in the completion of tasks, unimpaired by infantile inferiority" (1964, p. 124). Inferiority seems to be much less well-described than both industry and competence. It is described in *Childhood and Society* (1950) as "a sense of inadequacy and inferiority. If he despairs of his tools and skills or of his status among his tool partners, his ego boundaries suffer and he abandons hope for the ability to identify early with others who apply themselves to the same general section of the tool world" (1950, p. 227).

Erikson anticipated a number of the areas that eventually became more widely articulated and described as necessary for a contemporary developmental or life course theory, such as continuity, nonlinearity, and adaptation to changes in the times. So this paper has had a rather circuitous journey with the enlightening discovery that, on re-reading Erikson carefully, he actually anticipated future trends in developmental theory and research through his formulations and adaptations of the earlier works in the later ones. Particularly presciently, he talked about strengths before the positive psychology and resilience concepts became so prominent in modern-day psychology. His constant revisions of his own concepts and theories over the years provides a rationale for the continued reexamination of his monumental work.

So, while Erikson's life cycle theory still needs to be reconceptualized in the contemporary context, nonetheless Erikson's ideas still contribute to his own perpetuity, leading to a sense of comfort that reworking him, so to speak, actually enables his work to remain deservedly in the forefront.

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ERIKSON AND ADOLESCENT DEVELOPMENT: CONTEMPORARY VIEWS ON AN ENDURING LEGACY

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Abstract: Many of Erik Erikson's theoretical contributions to our understanding of adolescent psychosocial development endure; some have even proven to be true. At the same time, in the decades since Erikson's seminal works there have been many advances in developmental theory, especially in the realms of identity and positive youth development, along with important critiques of adolescent psychosocial theory. Together, these advances and critiques provide new lenses through which Erikson's work may viewed. The present work thus reviews the enduring concepts and qualities as well as limitations of Erikson's views on psychosocial development in adolescence, while considering possible expansions in light of contemporary identity theories and technological advances.

Keywords: Erikson, adolescence, development, identity

Many decades after the publication of his seminal works, Erik Erikson's theories on adolescent psychosocial development remain relevant, vital, and even prescient. At the same time, subsequent advances in developmental theory, especially in the realms of identity and positive youth development, invite a reexamination of Erikson's work. Here, we offer an appreciation of these enduring qualities that can reinvigorate adolescent psychosocial theory by way of integrating contemporary perspectives.

Erikson's Enduring Contributions

Identity Formation As the Central Task of Adolescence

Many of Erikson's ideas about adolescence have endured, but none as prominently as advancing identity formation as the central theme of the psychosocial crisis of this life stage, "identity vs. identity confusion." Though Erikson was not the first to delve into the concept of identity, he was the prime initiator of a field of inquiry into this concept. Erikson's stage theory of development suggests before one is psychosocially equipped to engage in the work of identity formation, one must emerge from the preceding stage of childhood with "a sense of being able to make things and make them well" (1968, p. 123), or what he called "industry." If there is instead a negative resolution of the childhood psychosocial crisis—which

Erikson called "inferiority"—identity formation in adolescence is handicapped. In turn, the satisfactory achievement of identity in adolescence is essential for productively solving the crisis of the adulthood stage to follow, "intimacy vs. isolation." In this way there is a continuity and sequentiality in Erikson's ontogenetic perspective.

According to Erikson (1956), identity "connotes both a sameness within oneself (selfsameness) and a persistent sharing of some kind of essential character with others" (p. 57). This notion of selfsameness or continuity of self helps accommodate the myriad physical, cognitive, and role changes inherent to adolescence, along with "all the confusing social cues of early life," ultimately serving as the mechanism "which gradually unites the inner and outer world" of the youth (p. 82; see also Hart, Maloney, & Damon, 1987). This idea of selfsameness is often called temporal-spatial continuity: A well-developed identity embraces a sense of sameness both across time and in different contexts (e.g., family, work). Côté & Levine argued that this idea is the most central in Erikson's theory of identity (1988), and from it is born a sense of invigorated self. To illustrate this notion, Erikson (1968) cited William James:

> A man's character is discernable in the mental or moral attitude in which, when it came upon him, he felt himself most deeply and intensely active and alive. At such moments there is a voice inside which speaks and says: This is the real me! (1920, p. 199).

Erikson (1968) stated that identity formation "arises from the selective repudiation and mutual assimilation of childhood identifications and their absorption in a new configuration" (p. 159). Particularly operative here is Erikson's use of the term *selective*. Indeed, he was clear that identity is not merely "the sum of childhood identifications. It is the inner capital accrued from all those experiences of each successive stage, when meaningful identification led to a successful alignment of the individual's basic drives with his endowment and his opportunities" (p. 94). This alignment of drives, endowment, and opportunities leads, ultimately, to the contents and commitments of oneself: "These new identification . . . force the young individual into choices and decisions which will, with increasing immediacy, lead to commitments 'for life'" (p. 155).

That the absence of some sense of one's commitments for life in adolescence may inhibit identity development was made evident in another of Erikson's (1968) references to James. Erikson notes (citing Matthiessen, 1948) that at age 26 James confessed, "Much would I give for a constructive passion of some kind" (p. 209). Indeed, this need for a "constructive passion" highlights not only the centrality of purposeful pursuits toward optimal identity development, but also forecasts a major theme in contemporary psychology on the nature of positive development and thriving in adolescence (Benson & Scales, 2009; Bundick, Yeager, King, & Damon, 2010).

Identity Development As Inherently Relational

It takes more than predetermined readiness by persons to address successive crises to propel growth. According to Erikson (1968), identity is "dependent on the process by which a society (often through subsocieties) identifies the young individual . . . A community's ways of identifying the individual, then, meet more or less successfully the individual's ways of identifying himself with others" (p. 159). As reflective of person-in-society, identity thus emerges not only from selection among childhood identifications, but further from "the way in which the social process of the times identifies young individuals—at best recognizing them as persons who had to become the way they are and who, being the way they are, can be trusted. The community, in turn, feels recognized by the individual who cares to ask for such recognition" (1982, p. 72).

In these reflections, we see not only that Erikson acknowledged the relational nature of identity, but a bi-directionality of influence between young persons and their communities. This idea that development occurs at the interface of the person and society (and its demands and support; see Schwartz, 2001) remains a theoretical tenet of many contemporary developmental theories. Relational developmental systems theory (Ford & Lerner, 1992; Overton, 2006), has its roots in Bronfenbrenner's (1979) ecological systems theory and Brandstädter's (1984) action theory: Humans are active producers of their own development through interdependent relations between individuals and the multiple levels of their ecologies (see Lerner, Dowling, & Anderson, 2003). Erikson acknowledged that young people can influence their communities insofar as the community feels recognized when the young person cares to ask for such recognition. At the same time, Erikson did not elaborate on this notion of bidirectionality, nor did he explore in any depth the mutually beneficial interactions youth could have with their communities. According to relational developmental systems theory, these interactions in turn contribute not only to the identity formation of the youth but also the identity assumed by the community as supportive of its youth (Benson, Leffert, Scales, & Blyth, 1998).

Psychosocial Moratorium

Though he generally focused on the development of identity as progressing in a relatively linear fashion, Erikson pointed out potential developmental benefits of what he called a "psychosocial moratorium." This is a socially-sanctioned time when one can experiment with roles and discover where there is a match between one's passions and socially desirable, vocational, and community roles. Erikson described this concept of moratorium as a distinct period

> The individual through free role experimentation may find a niche in some section of his society, a niche which is firmly defined and yet seems to be uniquely made for him. In finding it, the young adult gains an as-

> sured sense of inner continuity and social sameness which will bridge what he was as a child and what he is about to become, and will recognize his conception of himself and his community's recognition of him (1956, p. 58).

Such a planned delay does not suggest a withdrawal but instead an active (if uneven) process of exploration "by regressive recapitulations as well as experimental anticipations, often aggravated by an alternation of extremes" (Erikson, 1982, p. 100). Furthermore, Erikson characterized a psychosocial moratorium as "a selective permissiveness on the part of society," typically culminating in a "commitment on the part of youth [ending] in a more or less ceremonial confirmation of commitment on the part of society" (Erikson, 1968, p. 157). Here again we see the interplay between the young person and his or her social environment. In contemporary society, psychosocial moratoria, especially in later adolescence often take the form of attending college, participating in a study abroad program, working at an internship, or engaging in a service program like AmeriCorps, City Year, or the Peace Corps.

Additional Enduring Contributions Related to Adolescent Development

Erikson's contribution to our understanding of youth development cannot be reduced to identity formation alone; indeed, Erikson incorporated a number of other critically energizing dynamics that foster development in adolescence. Three of these include: a) a focus on virtues as psychosocial strengths, b) the notion of the epigenetic principle, and c) the role of technology in adolescent development.

Virtues as Strengths. Erikson proposed what he called "virtues" or "inherent strengths" for each of his stages of psychosocial development (1968, p. 328). The virtue of adolescence is fidelity. "Fidelity," Erikson (1962) wrote, "when fully matured, is the strength of disciplined devotion. It is gained in the involvement of youth in such experiences as reveal the essence of the era they are to join—as the beneficiaries of its tradition, as the practitioners and innovators of its technology, as renewers of its ethical strength" (p. 23). In describing this strength, he stated "The adolescent looks most fervently . . . for adults and ideas to have faith in . . . and in whose service it would seem worthwhile to prove oneself trustworthy . . . However, adolescents fear a foolish, all too trusting commitment, and will, paradoxically, express [their] need for faith in loud and cynical mistrust" (1968, p. 129). Fidelity, thus, is also an inherently relational notion.

Erikson's acknowledgement of these virtues in some ways foreshadows the strengths-based or assets-based approach to adolescent development, namely, "positive youth development." The successful navigation of adolescence cannot be marked simply by the absence of psychosocial deficiencies or the mere achievement of competence in identity formation or other developmental domains (e.g., school, family, community). According to W. Damon, this approach "envisions young people as resources rather than as problems for society [and] emphasizes

the manifest potentialities rather than the supposed incapacities" (2004, p. 15). Erikson acknowledged the importance of assets in his formulation of psychosocial virtues, yet he focused only on one virtue in each life stage, whereas contemporary theories of youth development entail young people embodying a great variety of virtues, and their development is affected by the presence (or absence) of various community assets. The Search Institute's 40 Developmental Assets framework (Benson, 1997) includes a set of key internal (individual) and external (community) assets that contribute to the positive development of youth (one grouping of which incorporates the notion of "positive identity"). Lerner's 5 C's of Positive Youth Development model (2004) focuses on a grouping of identity-relevant adolescent strengths including competence, character, connection, confidence, and caring or compassion. Both of these prominent models maintain, as did Erikson, that youth develop a sense of self through constant interactions with their environments; indeed, Erikson's framework included the building of trust and mutual faith between youth and their communities. However, Erikson's approach did not include all of young persons' assets, which, from a contemporary view, contribute to an identity that not only gives them a sense of their place in the world, but gives them full license to see themselves as active contributors to it.

The Epigenetic Principle. One of the major issues in theories of human development includes how the theorist understands growth. How and why do persons grow from A to B? What forces inside and outside the person explain change over time? Erikson (1968) used as his main thesis the epigenetic principle: "Anything that grows has a ground plan, and that out of a ground plan the parts arise, each having its time of special ascending, until all parts have arisen to form a functioning whole" (p. 92). In this light, persons unfold according to a prescribed sequence of stages. The energy that propels growth is the "crisis" in each stage (such as the adolescent crisis of "identity vs. identity confusion"). Satisfactory resolution of the crisis of each stage informs the shape and ease of later growth. For example, persons in early adulthood who are facing the "crisis" of "intimacy vs. isolation" has a leg up if they emerge from adolescence with a firm sense of identity. As evidence of this, successful identity development has been found to promote a healthier grasp of romantic relationships (Beyers & Seiffge-Krenke, 2010).

The Role of Technology. Often not mentioned by scholars of his work, but of great importance to those interested in updating it, Erikson acknowledged the role of technology in the psychosocial development of youth—a notion which bears particular importance in today's ubiquitously cyber-connected world. "That part of youth," Erikson (1968) wrote, "will have the most affirmatively exciting time of it which finds itself in the wave of a technological, economic, or ideological trend seemingly promising all that youthful vitality could ask for" (p. 129). He also asserted that adolescent development benefits from "the pursuit of expanding technological trends, [enabling youth] to identify with new roles of competency and invention" (p. 130). However, Erikson did not overemphasize the importance of

technology. On one hand, he stated, "There is no reason to insist that a technological world, as such, need weaken inner resources of adaptation, which may, in fact, be replenished by the good will and ingenuity of a communicating species" (Erikson, 1964, pp. 103–104). On the other hand, he stated, "The technological world of today is about to create kinds of alienation too strange too be imagined" (Erikson, 1964, pp. 104–105). Indeed, evidence of this is the growing prevalence of cyber-bullying (Kowalski, Limber, & Agatston, 2008) and concerns about "internet addiction" in many youth and their consequent withdrawal from society (Young, 2009).

Critiques and Expansions of Erikson's Theories of Adolescent Development

Despite the broad influence of Erikson's theories of adolescent development, they have not been above criticism. Though Erikson did make a passing note of the importance of subidentities such as ethnic and sexual, his cursory exploration of them has invited some criticism. For example, Sneed, Schwartz, and Cross (2006) reviewed the identity literature—starting with Erikson and into the present day—from a multicultural perspective, and reported that despite an emergence of research on ethnic and race identity, it is still unknown to what extent Erikson's psychosocial theory applies across subgroups. Moreover, Sorell and Montgomery (2001) maintained that Erikson's theorizing gave priority to a masculine orientation toward individuality and agency over a feminine orientation toward connectedness and nurturance. Levine (2002) built on this critique by asserting that gender differences serve best as "a proxy for the more fundamental distinction between the ideal-type identity constructions of independence and interdependence," through which women are more likely to "struggle to assimilate a sense of independence into [their] sense of an interdependent self" and men "struggle to assimilate a sense of interdependence into an independent sense of self" (p. 273).

Another important critique of psychosocial theory is that, despite his acknowledgement that not all development is linear, Erikson posited a stage theory in which humans typically progress from one stage to the next and encounter the psychosocial crises sequentially. Stage theories have for many years been brought into question (Flavell, 1977). Bandura (1998) stated that human functioning is simply "too multifaceted and multidetermined to be shrunk to a few discrete categories," that humans typically "do not exhibit a stable progression through the postulated sequence" of developmental stages, and that "where stages differ in gradation rather than in kind, the notion of stage progression is stripped of meaning or simply acknowledges the logical necessity that a brief adoptive duration precedes a longer one" (pp. 309–310). Baltes (1997) took a similar position, saying that the prominent role taken up by relational developmental systems theories in contemporary developmental psychology (as discussed earlier) is a testament to the "multicausality, multidimensionality, multidirectionality, and multifunctionality" of human ontogenesis and inadequacies of stage theories (p. 369).

Erikson's work has also been criticized as lacking in rigor and being unamenable to operational definition (Côté & Levine, 1987). One of the more prominent theoretical advances of Erikson's theories of identity that addresses these concerns can be found in the work of James Marcia (1966). Marcia postulated four ways to resolve identity crises:

- Identity diffusion in which a young person has not yet explored different ways of being in the world nor made choices about vocation or ideology
- Identity foreclosure in which one makes commitments to a certain kind of life without wrestling with options or possibilities
- Identity moratorium in which one is in the midst of wrestling with options but has not yet committed to an identity
- Identity achievement in which one has experienced an identity crisis, evaluated possibilities, and made a commitment to live in a way that has temporal and spatial continuity
- This fourfold framework and its measurement system have spawned several hundred studies as well as a number of critical reviews (Côté & Levine, 1988; Van Hoof, 1999)

Many other extensions of Erikson's (and Marcia's) work have since been proposed. Among them, Grotevant (1987) asserted that the identity exploration process is a function of young persons' skills (e.g., perspective taking or critical thinking) and their orientation toward (or away from) exploring their identities. Berzonsky (1990) also focused on process, adding three sociocognitive processing orientations: the informational style (active seeking of identity-relevant information), the normative style (closed-minded reliance on parental or social norms), and the diffuse or avoidant style (general evasiveness of identity issues). Waterman (1990) observed two different forms of achieved identity, one motivated primarily by extrinsic factors and the other motivated by a more intrinsic source he called "personal expressiveness," marked by a sense of purpose and fulfillment. Côté (1997) took a more sociological perspective on identity development in his identity-capital model, focusing on the role of social structures in identity formation and the degree to which identity components permit the accrual of social capital. Moreover, diverse subfields of identity have garnered much attention in recent decades. Beyond the focus on ethnic and racial identity reviewed by Sneed et al. (2006; see also Phinney, 1990) and the call for a greater understanding of gender identity by Sorell and Montgomery (2001), the field has been expanded to include moral identity (Blasi, 1984; Hart & Fegley, 1995), civic identity (Yates & Youniss, 1999), and religious and spiritual identity (see Roehlkepartain, King, Wagener, & Benson, 2006). Together, these theoretical extensions have helped to provide greater depth and breadth to Erikson's original formulation of identity development in youth.

Identity: Youth and Technology

Since Erikson published his defining works, of the ideas he integrated into his theories, perhaps none has developed at a faster rate and with greater consequence than the effects of technology. While prescient in his assessment of the importance of technology in the development of youth (and its potential to contribute to their senses of both connectedness and alienation), Erikson could not have envisioned the prominent role digital technologies play in the lives of today's adolescents. Undoubtedly, cell phones (and with them the capacity to communicate via text messaging) and the Internet (especially using social networking sites like Facebook and Twitter) are redefining how young people connect with each other and their electronically connected world. How these new rules of socializing might change psychosocial development, and how one thinks of one's digital self vis-à-vis one's real self, remains to be seen; to date, very little research has investigated such nascent developmental phenomena (Hinduja & Patchin, 2008). While this technological trend may indeed be promising all that youthful vitality could ask for, it is yet to be determined whether the perils are offset by the promises.

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ERIKSON'S YOUNG ADULTHOOD AND EMERGING ADULTHOOD TODAY

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Erikson's Young Adulthood and Emerging Adulthood Today

In the 60-plus years since Erikson presented his lifespan stage theory in *Childhood and Society*, not much has changed in the social and cultural context of the early stages. Infants still need to establish trust with someone who will love them and take care of them, incapable as they are of providing for their own needs. Children in early childhood still learn to walk and talk and do some things for themselves. Children in middle childhood still begin to learn to use the tools of their culture, usually by going to school. Adolescence is still a time when identity issues begin to move to the forefront. Building upon successes with these developmental tasks, Erikson saw young adults' psychosocial challenge as "intimacy versus isolation" (Erikson, 1950).

Today Erikson's ideas about this stage are incomplete. Erikson did not specify ages for his stages, but adolescence presumably comprised then, as it does now, the years between reaching puberty to attaining physical and sexual maturity, that is, most of the second decade of life. Then comes young adulthood; and after that, middle adulthood. This means that, in its original formulation, Erikson's "young adulthood" comprised a long stretch of the lifespan, at least a 20 year period, from about age 20–40. Today, it seems that achieving intimacy is only one of the psychosocial challenges that these decades bring.

Young Adulthood—Then and Now

Seeing intimacy as the key psychosocial issue of young adulthood made sense in 1950. At that time, by age 20 most young people in developed countries were finished with their education (only about 25% obtained postsecondary education, predominantly men). Young men, at least, had gone to work for an employer they would be likely to have for a long time. By that age, too, young people were married or about to be married, and had become parents or were about to become parents. Hence, they had constructed or were in the process of constructing the structure of their adult lives, in love and work. During their young adulthood, the couple would go on developing their lives in love and work, as their marriage continued and as they raised children together—probably three or four of them, in those days, if they were Americans.

However, in the 60-plus years that have elapsed since Erikson proposed his

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lifespan theory, the early part of what he called "young adulthood" has become unrecognizable from what it was then. "Thirty is the new twenty," as the popular phrase goes, and there is a good reason it has become popular: The structure of a stable adult life is not built at 20 but closer to 30. For most young people, the twenties are no longer a time of settling into the structure of a stable adult life, but a time of maximum disorder, unpredictability, and change. Marriage and parenthood take place in the late twenties or early thirties, more young people pursue education for longer than ever, and job changes are frequent.

Given these changes in how the twenties are experienced in developed countries, there was a need for a new way of thinking about this time of life as a developmental stage or phase. In 2000, Arnett proposed the idea of "emerging adulthood" as a new life stage between adolescence and young adulthood. The idea was widely embraced in the decade that followed; as of July 2011, the article that originally presented the theory had been cited more than 2,000 times, according to googlescholar.com. Clearly there was a widespread sense that a new theory and a new term were required to reflect the changes in development during these years (Arnett, Kloep, Hendry, & Tanner, 2011).

Arnett (2004) proposed that five features distinguished emerging adulthood as a developmental stage:

- the age of identity explorations
- the age of instability
- the self-focused age
- the age of feeling in-between
- the age of possibilities

To even a casual student of Erikson, it is the first feature that jumps out immediately. What is identity development doing there, when it has long been associated with adolescence? Arguably, in fact, one of Erikson's most influential contributions was his ideas about identity development in adolescence in *Identity, Youth, and Crisis* (1968). Is not identity achieved by the end of adolescence, as a prerequisite for being ready for the challenges of the life stage that follows?

Perhaps this was true in 1950, but now we live in the next century. The kinds of identity explorations Erikson described, the search for a place in one's society in "love and work" (the famous axiom Erikson attributed to Freud) still begins in adolescence, but it is certainly not resolved or achieved by the end of it. Most of the action in identity development, particularly in role-related identity, now takes place in emerging adulthood, not adolescence. First romantic and sexual relationships may occur in adolescence, but most people are not seriously looking for a life's partner until emerging adulthood. First jobs may occur in adolescence, but it is not until emerging adulthood that people begin a serious search for work they

plan to be doing for many years to come. Erikson, in fact, saw this change coming, in his idea of the psychosocial moratorium “during which the young adult through free role experimentation may find a niche in some section of his society” (1968, p. 156). Young people following this route were described by Erikson as following a relatively unusual path through this stage of life, but since the time he wrote those words, what was unusual has become normative, as a part of the new life stage of emerging adulthood.

Another observation that should be made about Erikson’s ideas on young adulthood is that young adults are extraordinarily focused on developing an intimate relationship, to the neglect or exclusion of the rest of life. Erikson theorized that once individuals consolidated a sense of identity in adolescence, they were ready, in young adulthood, to establish real intimacy in their adult relationships. He saw a sense of identity as a necessary foundation for mutuality in many kinds of adult relationships: “The youth who is not sure of his identity shies away from interpersonal intimacy; but the surer he becomes of himself, the more he seeks it in the form of friendship, combat, leadership, love, and inspiration” (Erikson, 1959, 1980; p. 101).

Attractions and attachments were important in adolescence, he acknowledged, but did not necessarily involve a “true and mutual psychological intimacy” that would be possible in adulthood; to this he famously said, “the condition of a true twoness is that one must first become oneself” (p. 101). Erikson saw the particular psychosocial risk of this stage as isolation, which he described as a tendency to isolate, repudiate, or—if worse comes to worst, destroy—“those forces and people whose essence seems dangerous to one’s own” (p. 101).

While these notions highlight relational development as the key advance in this period, it is odd, especially since Erikson specified love, work, and ideology as three important aspects of identity development in adolescence. Love in adolescence becomes intimacy (vs. isolation) in young adulthood, but where did work and ideology go? Ideology is more important for some individuals than for others during this time, but certainly *work* remains a large part of life in emerging adulthood, young adulthood, and beyond, and it is a puzzling feature of Erikson’s theory that it drops out of focus between adolescence and young adulthood.

The Developmental Challenges of Emerging Adults

Traditionally, and certainly in Erikson’s time, the transition from adolescence into adulthood was marked by successfully meeting five challenges: leaving home, completing school, entering the workforce, getting married, and having children. However, entry into adulthood has become more ambiguous as the social timetables that were widely observed a half century ago no longer apply (Arnett, 2004; Settersten, 2011). Emerging adults meet these developmental challenges in a more gradual fashion; increasing numbers will never attain these long-held markers of adulthood as they elect not to marry or have children, cycle back and forth be-

tween working and obtaining more education or training, and move into or out of the family home to facilitate other goals.

The multiple role involvements that emerging adults now experience—even if transitory and stop-gap in nature—do facilitate continued identity development (Côté, 2006). While Erikson proposed that earlier psychosocial resolutions permit the attainment of subsequent developmental milestones, and that personality developments in identity and intimacy "increase the capacity to do well" (1968, p. 92), he also saw a reciprocal influence between engagement in social roles and psychosocial maturation.

Optimally, emerging adults eventually settle on an answer to the identity question of "who am I?" that includes long-term commitments in work and love. In fact, making commitments that express one's identity is a key to psychological health and well-being (Luyckx, Goossens, & Soenens, 2006). Those who commit to multiple roles in their 20's have greater identity development in their 40's: a stable personality, behavior that is consistent with internal standards, and independence blended with warmth and compassion (Vandewater, Ostrove, & Stewart, 1997). Consistent with Erikson's theory, a firm identity which includes both a coherent sense of self and a commitment to particular self-defined and self-defining roles better equips the young person to enter into true mutuality with another (Erikson, 1950; Markstrom & Kalmanir, 2001).

Value of Erikson's Theory

We who teach courses on lifespan or adult development to undergraduates or helping professionals have observed that Erikson's theory plays well with those who are themselves emerging adults. They see themselves as involved in the process of exploring and deciding upon the commitments in work and love that they will carry into the future. They resonate with the notion that their previous developmental attainments of (or difficulties with) hope, willpower, purpose, and competence have brought them to their present moment. Further, and especially important for those aspiring to careers in human services or education, they find Erikson's theory useful for providing a developmental explanation of problems ("How does someone get to be like that!?") and for offering a developmental roadmap for interventions designed to help people get their life back on track ("She needs to learn to trust life again, then she'll feel more like trying").

Although Erikson's limitations regarding culture and gender are obvious and have been spoken about by many (e.g., Gilligan, 1987), we find his theory has much to offer. It would be unfair to expect him, any more so than the rest of us, to rise above the cultural horizon of his times (see Sorell & Montgomery, 2001). Rather, his parsimonious explanation for the development through the lifespan offers a framework upon which more elaborate explanations can be for developed (e.g., Kroger, 2008). Alternatively, and in the case of Arnett's theory of emerging adulthood, contemporary developmental phenomena can be examined and used

to update Erikson's theory. Arnett and others have advocated extending the approximate age for consolidation of one's identity from adolescence into emerging adulthood, allowing for iterative processes in revising role-related identities and recognizing bidirectionality in the consolidation of a psychological sense of identity with the concurrent development of intimate relationships characterized by deep mutuality (Arnett, 2007; Bosma & Kunnen, 2001; Montgomery, 2005).

Erikson's theory is useful because it helps us to unify ideas about the lifespan in a general, memorable framework. Perhaps this explains its appeal to each new generation of students. At the same time, his theory implies unspecified processes, making room for the elaboration of notions with a wider range of contemporary applicability such as those offered by Arnett (2000; 2007) and Côté & Levine (2002).

Supports and Developmental Interventions for Emerging Adults

College itself is the most notable intervention during this stage; it is experienced by approximately half of the young adults in the United States and Canada. College is renowned for explicitly encouraging identity exploration of many types, including vocational identity, sexual identity, political identity, ethnic and racial identity. Does it indeed facilitate identity development? Certainly, aspects of cognitive development that promote identity exploration and commitment, such as critical and reflective thinking, are fostered by college experiences (Montgomery & Côté, 2003). College often catalyzes ethnic identity development, probably because of opportunities to access groups and courses of study organized around race. Among minority immigrant young people, college can increase aspirations to do something they like and to be the kind of person they feel they are (Fuligni, 2007, p. 99).

The opportunity to explore options is certainly present in college, but as noted above, being able to make commitments to roles, values, and relationships that express one's identity is also essential. A longitudinal study of identity processes during the first two years of college revealed that emerging adults do explore multiple possibilities in many domains and they also evaluate existing identity commitments. Most students cycled between making commitments and then reevaluating these commitments (Luyckx, Goossens, & Soenens, 2006). Students who evaluated and became more certain of their commitments were better adjusted academically and socially. However, those who explored multiple possibilities without making commitments were more poorly adjusted—more depressed and higher in drug use (Luyckx et al., 2006). Thus, it may be important for higher education to find ways to provide more assistance to students in choosing and making commitments than have been available to date. For example, rather than leaving academic and career guidance to untrained advisors, colleges could make working closely with a career guidance professional an expected or required aspect of postsecondary education (Herr, Cramer, & Niles, 2003). Also, youth not attending college can benefit greatly from a mentoring relationship in which they are both supported and challenged as they make life-shaping identity commitments (Tan-

ner, 2006).

Conclusion

Erikson's stage theory of the lifespan has been enormously influential in the decades since it was proposed, and like all good theories it has generated a great deal of research. Although he proposed it as a universal theory, from our perspective 60-plus years later, we can see that it was very much a product of its time and place. His ideas about young adulthood in many ways do not fit today's world, perhaps more so than any of his other life stages. Even the greatest theories require modification and change in the long run of science.

One of the most valuable contributions that Erikson's theory made is to show how useful and productive it can be to think of human development in terms of life stages (Arnett et al., 2011). This view, too, has been questioned ever since he proposed his theory, and there are many developmental scientists today who question the value of theories of life stages or even find them to be obstacles to understanding development (Côté & Bynner, 2008; Hendry & Kloep, 2007). However, we believe that Erikson has shown that thinking of development in terms of life stages inspires research and promotes deeper insights into human development. His ideas about young adulthood are dated, and it may be that other parts of the theory are in need of revision to fit our times and to articulate more fully than Erikson that cultural context always matters and that there is a limit to what can be considered universal in human development. Nevertheless, Erikson remains a vital part of the scholarly conversation about human development in the 21st century, including the conversation about the third decade of life.

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A TIME OF TRANSITION: THE IMPACT OF RURAL YOUTH SERVICES ON EDUCATION, HOUSING, AND EMPLOYMENT

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ABSTRACT: The transition to adulthood can be a difficult process for any youth. This paper explores an outcome-impact assessment of the Intensive Transitions Treatment (ITT) Program. This service system works with youth facing the challenges of mental illness, substance abuse, and involvement with CYS or Court Supervision Services, with little, if any, support for the transition to adulthood. The primary adult living domains of education, housing, and employment are examined both qualitatively and quantitatively at different points of program involvement. The findings indicate program achievements, opportunities for improvement, and the need for additional research regarding intensive services and relevant supports. Implications for comparable youth programs and resources, service staff, policymakers, and community members are discussed.

Keywords: rural youth, child welfare, youth service programs

Marcus is a 21-year-old biracial male living in rural Pennsylvania. He has been involved with the child welfare system for years, including a boot camp, at least three residential stays, and foster care. He has faced legal issues and a past probationary status of approximately two years. He has no relationship with his father, a tumultuous connection with his mother, and several challenging diagnoses (e.g., borderline personality disorder). Marcus connected with the Intensive Transitions Treatment (ITT) Program after a referral from his personal care home; a recommendation was made to maximize independent living skills, with the hope of enabling him to live in the community one day, despite relatively few local transitional housing options.

Marcus entered into the ITT Program at the age of 19. Treatment plan goals included living independently, improving relations with his mother and peers, getting gainful training and employment, and being able to take medications appropriately. He also expressed interest in learning more about his ethnic heritage (which was unique in his county of residence). During the first year of program involvement, provided services included several in-person contacts, all of which took place in his personal care home. No residential moves or hospitalizations were indicated. During a focus group, Marcus stated that the ITT staff "Keep me out of trouble," and that his goal was "Try to get a place of my own."

At the age of 20, Marcus provided more positive feedback during his second year of program involvement. He shared successes and planning in domains of employment and volunteering, education, independent living, and legal matters. He stated, "I'm working at the hospital," and "Physical therapy assistant .

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. . that's my main goal." Marcus also said, "Now I live on my own," and "Gotta give credit to [staff name] . . . she helped me get my record expunged." He also denied any crises.

Marcus's mother confirmed that the ITT Program led to improvements with independent living and related areas like cooking. Other noted successes were decreased aggression and improved anger management, successful home-based meetings, and personalized case management and skills training. His mother also stressed her son's hospital volunteering and future goals of specialized training. A former residential treatment service provider described the case of Marcus as a large success. Within 1.5 years of his being referred to the ITT program, he was living alone, setting realistic future educational goals, and receiving an award for his volunteer work. The provider said, "He wouldn't have been as successful without them."

The transition to adulthood, including exploration of self, environment, possibilities, and perspectives, could be a challenge for any young individual (Arnett, 2000). As the case of Marcus demonstrates, both his rural residency and child welfare system involvement complicated the move to adult living (Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001; Crockett & Bingham, 2000; Small & Memmo, 2004). Various services across the United States have been implemented to support and aid subpopulations entering young adulthood. One such initiative is the ITT Program, located in a rural county in northwestern Pennsylvania. This article describes ITT and all aspects of an assessment of this program's impacts on consumers' employment, housing, and education statuses. Thus, it will be indicated whether or not ITT encourages and aids youth consumers in three primary domains as they transition to adulthood. The goal of this investigation is to demonstrate if success stories (such as that of Marcus) are widespread in the ITT consumer population and what opportunities for improvement exist.

Relevant Literature

Arnett (2000) defines emerging adulthood as a distinct life period during which youth experience "change and exploration . . . examine the life possibilities open to them and gradually arrive at more enduring choices in love, work, and worldviews" (p. 479). Thus, the move from adolescence to more mature life stages is a complex and dynamic process that can be affected by several factors. All youth encounter some challenges as they exit childhood and enter young adulthood, and these obstacles may be due to or intensified by emotional disturbances or other life circumstances (Heflinger & Hoffman, 2009; Keller et al., 2007).

Adolescents aging out of the child welfare system are in an exceptional position. The Midwest Evaluation of the Adult Functioning of Former Foster Youth indicates that there may be unique vulnerabilities, such as history of abuse, that create subgroups of young adults emerging from foster care (Courtney et al., 2010). Each of these smaller populations, as well as the individuals within these groups,

could possess distinct problems and related effects that will shape adulthood. In addition, these youth might be challenged to find a balance between independence from child welfare services and the necessary continuing support for emotional and mental well-being, housing, and other requirements (Wells & Zunz, 2009). These issues provide some insight into why individuals who have aged out of the foster care system exhibit more unemployment, less educational attainment, greater homelessness, and additional problems than their peers one year later (Courtney & Dworsky, 2006).

Courtney et al. investigated 141 adults leaving foster care in 1995-1996; consumer reports of maltreatment during system involvement, social support disruptions, and system departure prior to age 18 were identified contributors to the difficulty youth experienced during the shift to independence (Courtney et al., 2001). Out-of-home placements remove an individual from his or her familiar others and environment and thus may add to or complicate these challenges (Keller et al., 2007). Perhaps the individual loses a place that provides comfort, or no longer has a familiar adult to model him or herself after. Further obstacles could arise if the young adult has both mental health and substance use issues but is only receiving treatment for one problem type, rather than cooperative mental and behavioral health services (Anderson & Gittler, 2005; Courtney, Hook, & Lee, 2010). For any or several of these reasons, youth may possess vulnerabilities (partly) as a result of what they experienced while involved with the child welfare system.

Young adults in rural areas face additional challenges. Rural areas might offer resources like cleaner air or large backyards, but also create difficulties of insufficient mental and physical healthcare, limited public transportation, limited employment options, poverty and economic uncertainty, and stigma when using social services (Crockett & Bingham, 2000; Puskar, Serika, Lamb, Tusaie-Mumford, & McGuinness, 1999; Saywell, Zollinger, Schafer, Schmit, & Ladd, 1993). These factors could explain why youth in rural locations tend to expect to become adults sooner than their peers in urban and suburban areas (Crockett & Bingham, 2000). Additionally, this might be why such youth have been found in co-occurring high-risk groups of mental health, substance use, behavioral and developmental disabilities, and frequent service users (Crockett & Bingham, 2000; Heflinger & Hoffman, 2009). Heflinger and Hoffman (2009) found that when compared to urban youth, rural adolescents are more likely to be at high risk for difficulties (e.g., having a substance use issue) during the transition to adult living. Youth with co-occurring conditions could be further challenged by lacking and varying treatment options in rural areas; trends suggest that individuals in such settings who are less depressed, more antisocial, or struggling with other complications may be less likely to receive cooperative services (Anderson & Gittler, 2005).

Heflinger and Hoffman (2009) found in a unique study that rural living can cause difficulties during the entrance into adulthood and that participation with

the foster care system was a primary factor that increased and intensified such risk. Thus, youth who are involved in the child welfare system and living in rural areas could be particularly vulnerable due to overlapping risk factors. The unmet needs, frequency of co-occurring conditions, and lack of coordinated mental and behavioral health care for youth in rural settings and for those departing from the child welfare system have been demonstrated in several studies (e.g., Anderson & Gittler, 2005; Courtney et al., 2010; Keller et al., 2007; Wells & Zunz, 2009). McGuinness (2009) identifies rural foster care participants as a population that is nearly invisible to researchers, policymakers, and service providers. Existing programs and services are generally segmented for either rural young adults (i.e., 4-H) or foster care youth (i.e., Regional Youth Services); the former type has goals like improving school performance, and the latter has goals for achievements of family reunification or independence (National 4-H Council, 2010; Regional Youth Services, Inc., 2008).

This paper will build upon limited existing literature and investigate if an intensive program specific to rural areas assists system-involved youth as they transition to adulthood. The ITT program supports Marcus and other rural young adults as they exit child welfare or related services. Thus, the program identifies and aids a population that might be challenged by both their residency location and their unique entrance into adulthood. Evaluation may encourage awareness to policymakers, staff, and community members. Additionally, ITT implements the aspects (i.e., consideration of youth perceptions) recommended to improve transitional services. This exploration will potentially show the value of these or other key elements, as well as encourage the maintenance and improvement of ITT and other related services.

Research Questions and Hypotheses

In the current project we investigated the impact of ITT participation on youth consumers' employment, housing, and education. These areas were selected for investigation because they are often primary determinants of an individual's successful adult living. We asked these questions:

- "Does ITT Program participation impact a youth's employment status?"
- "Does ITT Program participation impact a youth's residential status?"
- "Does ITT Program participation impact a youth's educational status?"

We hypothesized that ITT participation would positively affect the domains of interest and that longer enrollment in the ITT program would be related to greater change when compared to shorter involvement timeframes.

ITT Program Description

The ITT program was established in 2008 to assist youth with their preparation for adult life. Intended long-term outcomes of ITT involvement include healthy living, support networks, and, when applicable, recovery or sobriety; intended community outcomes include decreased institutionalization costs, housing stability, and academic or employment achievements of residents (Transitional ACTion Team Logic Model, 2008). Aspects of Assertive Community Treatment, Transitions to Independence, and Partnership for Youth Transition programs have been blended together for the creation and implementation of ITT (Davis et al., 2009). Program team members include team leader, peer specialist, substance abuse specialist, transitional specialist, nurse, occupational or vocational specialist, and psychiatrist. ITT has a low consumer-to-staff ratio, shared caseloads, daily or as-needed contact between staff and consumers, related programs and services, and family involvement when applicable (Transitional ACTion Team Logic Model, 2008).

Recipients of ITT services are youths facing challenges of mental illness and substance abuse, involvement with CYS or Court Supervision Services, and little (if any) familial support for the transition to adulthood. Thirty-four youth had been involved with ITT at the time of this evaluation, and these individuals are predominately white males. Assessment, service planning, and delivery focus on the home and community; specific supports are mental health and substance abuse counseling, psychiatric care, skills training (i.e., financial planning), case management, crisis intervention, and health promotion (Transitional ACTion Team Logic Model, 2008).

Methods

Research Design And Data Collection Methods

A nonexperimental mixed methods design was used. The primary research methods of data collection included focus groups and review of assessment forms completed by the ITT staff at various points of the youths' program involvement. These forms are the Outcomes and Indicators tool and the Young Adults Needs and Strengths Assessment (YANSA) (Buddin Praed Foundation, 2009). Both forms were used to collect longitudinal data. The Outcomes and Indicators tool was to be completed by ITT staff at the 1-month, 7-month, and 13-month points, while the YANSA was to be used by the staff at baseline (e.g., the consumer's entry into ITT) and at the 12-month mark. Completed forms were analyzed for responses relevant to the areas of employment, housing, and education.

Sampling Techniques

The population for this evaluation was 34 current and previous ITT service recipients. Participation recruitment in the current evaluation was not necessary because it involves existing program data and releases previously obtained for broader ITT program evaluations. The focus group sampling frame consisted of 15 invited consumers who could self-select to participate. ITT staff reports, as well as researchers' review of consumer records, indicate that self-selecting members of the focus group were comparable to youth who did not participate. Institutional Review Board approval was obtained from the University of Pittsburgh to conduct this research.

Instrumentation

The focus groups questions included entry into ITT, staff members, changes and developments while involved with ITT, future goals, crises, medications, successes, failures, and adult living. The research supervisor and the ITT program director believed that the consumers would provide valid and reliable feedback. Outcomes and Indicators and YANSA data were collected from ITT records. Outcomes and Indicators consisted of 60 closed-ended items. ITT-created response possibilities were "yes," "no," "not applicable," or missing response to specific indicators within broad outcome types. "Not applicable" response examples involved items such as working 20 hours per week (if not having completed training or education) and missing fewer days of school than last year (if not enrolled in school). For consideration in this study, six indicators from four outcomes were pertinent: community stability, employment stability, educational attainment, and housing stability. Specific indicators were fewer out-of-home placements, fewer days in out-of-home placements, at least 20 hours of work per week, passing grades, fewer school absences, and safe housing.

The YANSA contained 59 closed-ended items. Topic headings included functioning, mental health, substance abuse, culture, educational or vocational, risk behaviors, strengths, and the (optional) caregiver needs and strengths. Residential stability, educational functioning, educational attainment, and job functioning were relevant to the selected domains. Ratings of "0," "1," "2," "3," or "unknown" were given for each item. The strengths assessment ratings range from a "0" for a present strength to a "3" for no current strength. All other ratings, including the relevant items, involve need and a range from a "0" for no need to a "3" for urgent need.

Data Analysis Procedures

Focus groups. Both of the focus groups were transcribed with indications of topic changes, happenings during the meetings, and stopping and starting points. All dialogue relevant to the target questions, ITT program and staff, consumer experiences, and the evaluation process was transcribed word-for-word. Tangents on matters not relevant to these topic headings, such as food, were indicated in brief summaries (e.g., "tangent on burning macaroni and popcorn"). Focus group transcripts were analyzed for information relevant to the domains of employment, housing, and education.

Outcomes and indicators. Within selected outcome measures, indicators of fewer out-of-home placements, fewer days in out-of-home placements, at least 20 hours of work per week, passing grades, fewer school absences, and safe housing (e.g., HUD-inspected and in a safe neighborhood) were analyzed. Data was entered into SPSS to obtain descriptive statistics. The frequency and proportion of all "yes," "no," and "not applicable" (or missing) responses were calculated for the selected indicators. The mean of responses at the 1-month, 7-month, and 13-month assessment-grouping points was also determined.

YANSA. YANSA topic headings included functioning, mental health, substance abuse, culture, educational and vocational, risk behaviors, strengths, and the (optional) caregiver needs and strengths. Scores were analyzed for specific items (i.e., family involvement, danger to self) within these domains. Descriptive statistics were calculated for the YANSA data. The frequency and proportion of scores "0," "1," "2," "3," or "unknown" was determined for baseline and the 12-month point of ITT program involvement for the selected items. In addition, the mean of scores was calculated for the baseline and 12-month assessment points. An independent samples t-test was then used to test if mean scores were significantly different at the .05 level.

Findings

Description of the Sample

The population for this evaluation was 34 current and previously enrolled ITT service recipients. The ages of the youth ranged from 15 to 25 years old, with more than 80% of the population being ages 18 to 22. The focus group sampling frame originally consisted of the 15 invited representative youth, but only 9 of the 15 invited consumers chose to participate. The sample for the Outcomes and Indicators and YANSA would ideally involve all 34 past and present consumers and their records at each assessment point. However, the Outcomes and Indicators sample consisted of 28 consumers at the 1-month point, 13 consumers at the 7-month point, and 3 consumers at the 13-month point. The YANSA sample was also smaller than expected, with 26 consumers at baseline and 5 consumers at the 12-month assessment.

Focus groups

Results from the focus group analysis were generally positive about the important (effective) elements of approaches in the ITT program. The first identified theme involved the multidisciplinary approach. Consumers expressed awareness of and gratitude for services regarding employment, housing, and education domains. One individual stated, "[Staff] and I work on a bunch of stuff . . . getting a place, getting a source of income." Landmark or daily improvement reports included, "I graduated," "I have a place of my own . . . I'm very independent," and "Move out and take a job . . . both worked out well."

A second major theme dealt with youth valuing practical support, such as assistance with senior class projects and employment referrals. Individualized support or help with needs was appreciated. Consumers provided specific examples of applicable and beneficial services, stating, "[Staff] was trying to help me with cyber school," "They said they would pay for me to be a [physical therapy assistant]," and "I was referred to [housing]."

Success variation emerged as a third theme from the focus groups. For some of the youth, locating a place to live or finding employment were not only necessary tasks but also significant successes. Other consumers expressed achievements that could suggest a higher level of goal setting and reaching, either independently or with ITT staff support. One youth, for example, shared the message, "I got enough in scholarships and grants that I got a free ride [to college]."

Specific goals and the length of youth ITT involvement were a final theme of the focus groups. Consumers who had been receiving program services for less than one year generally discussed future plans in a vague way. Clearer objectives were more often expressed by the youth who had been associating with ITT for at least one year. Specific notable goals by these individuals were, "I'm hoping to get my bachelor's degree in accounting," "I want to get [an apartment]," and "Physical Therapy Assistant . . . that's my main goal."

Outcomes and Indicators

All questions contained within the Outcomes and Indicators assessment form are worded in a positive way (e.g., a "yes" response indicates a positive indicator, such as working at least 20 hours per week). Thus, it was expected that "yes" responses were the majority response for all selected indicators of education, housing, and employment.

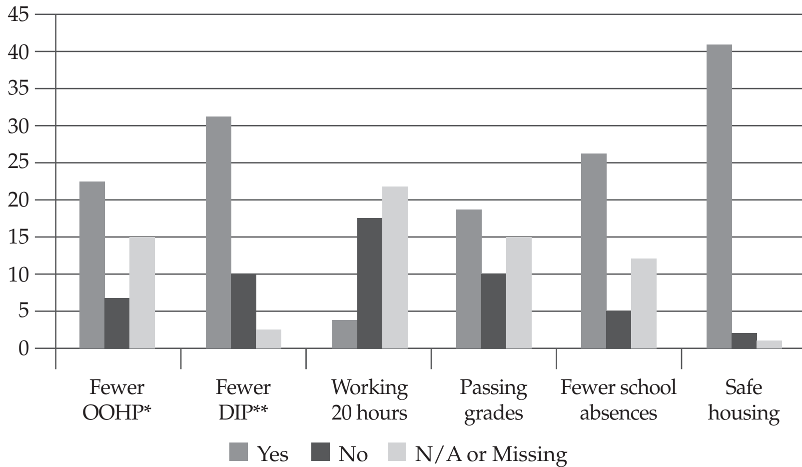

Figure 1: Frequency of Outcomes and Indicators Responses at 1, 7, or 13 month(s) of program involvement. This figure illustrates the proportion of desirable "yes" responses (and "no" and "not applicable" or missing responses).

* OOHP = Out of home placements; **DIP = Days in placements

"Yes" responses were the majority responses for the all indicators except working at least 20 hours per week. This indicator had most of its responses in the "not applicable" or missing category and the second largest response type in the "no" category. This finding might be due to the fact that consumers as young as 14 are participating with ITT services and are therefore too young to be working at this weekly rate, or might be due to the current economic environment locally and nationally. It was also hypothesized that the "yes" response would have the highest mean in all assessment groups, suggesting that participation with ITT is related to more positive indicators and outcomes. Additionally, it was expected that the mean of "yes" responses would increase with longer ITT program involvement.

Table 1: Outcomes and Indicators: Means of Responses

Time of Assessment	Proportion of Assessment	Mean of "yes" Responses	Mean of "no" Responses	Mean of "not applicable" or Missing Responses
1 month	63.6% (28)	30.47	22.21	2.11
7 months	29.5% (13)	41.62	11.92	3.08
13 months	6.8% (3)	35.00	20.33	1.00

The majority of the Outcomes and Indicators were administered when the consumer had been involved with ITT for 1 month. Fewer assessments took place at the 7-month mark and the least number of assessments occurred at the 13-month mark. This trend could be due to data not being completed as intended, or a result of consumers departing early from the ITT program. Analysis also revealed that the mean of “yes” responses was greater than the mean of “no” and “not applicable” or missing responses at all assessment marks and that mean “yes” responses increased from the 1-month to 7-month assessments. However, the “yes” response mean was greatest at the 7-month mark, rather than at the 13-month mark.

YANSA

We hypothesized that improvements in the domains of employment, housing, and education would be observed with longer ITT program involvement. We therefore expected that for residential stability, educational functioning and attainment, and job functioning, need ratings of a “2” (help is needed) or a “3” (help is needed now) would decrease from baseline to the 12-month assessment mark.

Table 2: Yansa Baseline and 12-month Assessment Needed Help Scores

	Baseline		12 months	
Domain	% of “Help is Needed” Responses (n)	% of “Help is Needed Now” Responses	% of “Help is Needed” Responses	% of “Help is Needed Now” Responses
Residential Stability	23.1% (6)	15.4% (4)	20.0% (1)	—
Educational Functioning	34.6% (9)	15.4% (4)	—	—
Educational Attainment	53.8% (14)	3.8% (1)	40.0% (2)	—
Job Functioning	61.5% (16)	11.5% (3)	40.0% (2)	—

Overall, youth exhibit higher levels of need and immediate need at baseline. Improvement (e.g., fewer “2” and “3” need scores at the 12-month assessment) is evident in all four areas of interest. The greatest positive change is in the educational functioning domain, while the most minimal improvement is in residential stability. Certain factors, including the limited amount of safe, affordable housing and independent living facilities in the surrounding county, could provide a context for these findings. Also the 12-month mark offers fewer YANSA measures to analyze. This decrease, potential consumer departure from ITT, and the longer duration of services might explain why there is less need demonstrated at the 12-month mark.

We expected YANSA mean score analyses to be similar to the frequency statistics. We thought, therefore, that lower mean scores of need would be demonstrated

at the 12-month assessment of the selected domains. This would demonstrate that ITT services decrease need exhibited by youth as they enter into the program.

Table 3: Yansa: Mean Scores of Need at Baseline and the 12-month Point

Domain	Baseline Mean Score (n=26)	SD	12-month Assessment Mean Score (n=5)	SD
Residential Stability	1.23	1.07	.60	.89
Educational Functioning	1.42	1.03	.20	.45
Educational Attainment	1.35	.94	.80	1.10
Job Functioning	1.77	.77	.80	1.10

On average, greater need scores were recorded at baseline. Scores at this point tended to range between a "1" score of watchful monitoring of need and a "2" score of help is needed. Mean scores at the 12-month mark were between a "0" score of no need and a "1" score of watchful monitoring of need. The wide range of standard deviations of scores should be noted for both assessments (particularly for educational attainment, which had the largest deviations). These suggest that certain youth may have experienced much greater or much less needs in the selected domains when compared to mean scores and to their consumer peers.

An independent-samples t-test was conducted to compare YANSA need scores at baseline and the 12-month mark. There was a significant difference in educational functioning scores for baseline (M=1.42, SD=1.03) and 12-month assessment (M=.20, SD=.45); t(29)=2.59, p =.001. A significant difference also was noted in job functioning scores for baseline (M=1.77, SD=.77) and 12-month assessment (M=.80, SD=1.10); t(29)=2.43, p=.02. No significant differences existed for residential stability scores for baseline (M=1.23, SD=1.07) and 12-month assessment (M=.60, SD=.89); t(29)=1.23, p=.23. No significant difference was identified for educational attainment scores for baseline (M=1.35, SD=.94) and the 12-month assessment (M=.80, SD=1.10); t(29)=1.17, p=.25. These results suggest that ITT involvement positively impacts educational and job functioning, but does not affect residential stability or educational attainment.

Overall findings of the study are mixed. The focus groups, the frequency of "yes" responses on the Outcomes and Indicators, and the YANSA descriptive statistics suggest that ITT involvement positively impacts employment, education, days in out-of-home placements, and housing safety. Inferential statistics also supported this idea with the YANSA domains of educational and job functioning. However, Outcomes and Indicators desirable "yes" responses decreased from the 7-month to 13-month mark, and inferential statistics did not demonstrate sig-

nificant differences from baseline to 12 months for YANSA residential stability or educational attainment. Thus, it appears that initial improvements were not necessarily maintained over time, and improved functioning did not universally translate to achievements such as steady work, graduation, or safe housing.

Discussion

Limitations

There are five limitations to this outcome and impact assessment. The first involves the small population size. Since the ITT program had serviced only 34 consumers at the time of this evaluation, data availability was limited by nature and provides only a glimpse at rural youth involved with the child welfare system. The second involves incomplete and missing data, as well as the self-selecting quality of the focus groups, which narrowed this scope further. The third is that the 1-month baseline assessments compose the majority of Outcomes and Indicators responses and YANSA scores. This distribution must be considered because available data is more frequently indicative of newly involved youth instead of ITT consumers throughout the duration of services. The limited amount of data at the 12-month mark could also have influenced the findings of greatest improvement occurring within the first six months of program participation.

The fourth limitation involves the differentiation of housing stability and housing safety concepts. Indicators of a youth having safe housing at the time of assessment do not necessarily mean that he or she is in a stable residence. The fifth is that the issue of concentrated treatment “dosing” at the start of a youth’s involvement with ITT should be explored further. While the introduction of intensive services appears to be creating positive change (particularly within the first 6 months of program involvement), maintained improved functioning is not strongly indicated by this study. This is likely related to the common challenge of maintenance of treatment gains; that is, initial improvements can be difficult to preserve and build upon as service options are used, limited, or exhausted, and actual progress does not always line up with early expectations. However, this finding may also be viewed as good news for service providers in that greater investments initially and for a short duration seem to foster success to some degree.

Implications and Conclusions

For community members and practitioners not affiliated with intensive support services, this study provides a context for (rural) independent services aiding youth in their transition to adult living. We explored three primary domains of adulthood, a service program designed to improve these areas, and the outcome measures of the study. Every social service organization and individual professional must consider outcome indicators, resource delivery, unique consumer elements, and the maintenance and improvement of their services through evaluation. ITT, exemplified in the

case of Marcus, indicate such possibilities and give a potential framework to follow.

We hypothesized that ITT Program participation positively impacts youth multisystem services with reference to achieving employment, obtaining safe and stable housing, and completing high school and obtaining post-secondary degrees. The findings are encouraging, particularly with regard to improving educational and job functioning. Quotes from focus group participants illustrate the success stories that support the maintenance of certain program aspects, such as individualized planning and practical help and support. The mixed findings, however, suggest that despite individual successes, broad improvements in employment, housing, and education domains have not been the case for all ITT consumers.

We offer several recommendations for programs aiding rural youth in their transition to adult living. First, there is a need for the monitoring of coordinated services and outcomes (Heflinger & Hoffman, 2009). Coordinated services encourage responding to risk and protective aspects, fitting aid to the home and community, and planning for how changes in one area may influence others (Bogenschneider, 1996). Such processes could permit unified expectations for independence, as well as the growth of youths' goals and supports beyond the foster care system (Courtney et al., 2010). Second, identification of those fitting into the subgroup of interest reinforces holistic assessments and results in more appropriate policies, practices, and resource distributions (Courtney et al., 2010; Keller et al., 2007). Third, evaluations of current services are necessary. Research might lead to removing barriers to treatment, valuing qualified staff, the establishing of concrete and creative supports, and comparing ongoing challenges facing rural youths aging out of child welfare services (Anderson & Gittler, 2005; Bogenschneider, 1996; Courtney et al., 2001). Fourth, the involvement of various life domains and a range of youths' strengths and risks are vital to a program's success (Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2004). Fifth, future analyses should target adolescent perceptions. Little research has been directed at the ideas and expectations of young people actually going through the transition to adulthood (Crockett & Bingham, 2000).

Our investigation revealed multiple effective strategies and actions. The success of Marcus suggests the value of community-based contacts, "collateral contacts" (i.e., follow-up phone calls), personalized case management, and supportive elements of broader goals (e.g., learning to cook as part of independent living). Marcus's case involved creative adaptations to employment and skills training by partnering a consumer with a volunteer organization with the potential of later being hired or being more educated. In rural areas where resources might be limited, collaboration could be the most effective way of addressing needs.

On a broader level, ITT puts many of the recommendations for rural transition services into action. The multidisciplinary team approach permits the coordination of services and outcomes in a holistic manner. The Outcomes and Indicators and the YANSA, assessment forms used by the program staff, also encompass a

wide range of items including life domains and strengths and risks. ITT addresses individual consumer perspectives and life situations and the importance of individual success. Staff and services are open to evaluation processes and serious consideration of adolescent perceptions. Perhaps the greatest achievements of ITT are evidenced by the consumer focus groups; here, the youth expressed appreciation for a range of supports, services, and creation of specific goals with longer program involvement. Providers in other relevant social organizations might reflect upon ITT and its success and opportunities for improvement to better plan and implement additional resources for the "almost invisible" (McGuinness, 2009, p. 55) rural child welfare population.

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YOUTH WORKERS IN MENTAL HEALTH CARE: ROLE, MENTAL HEALTH LITERACY DEVELOPMENT, AND FRAMING FUTURE RESEARCH

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Abstract: Youth workers' role in mental health care requires articulation and further examination. Establishing a role in the provision of mental health care leads to queries regarding youth workers' mental health literacy and what knowledge is required to have a presence among other mental health care providers. The aim of this paper is to articulate the current role of youth workers in mental health care, examine emerging perspectives in research and education on mental health literacy development, and encourage fresh directions for future education and research that are aligned within the physical and philosophical position of the youth work field.

Key words: youth work, mental health care, mental health literacy, gatekeeper training

Nearly two decades ago, White (1996) proposed that child and youth care professionals could participate in preventing youth suicide, "by virtue of their proximity to potentially vulnerable youth across a wide array of settings" (p. 48). While several articles in child and youth care and youth work academic journals have taken up aspects of mental health and suicide in practice (Banks & Bartlett, 2006; Broadbent, Corney, Plessis, & Papadopoulos, 2013), White's early proposition of youth workers' participation in suicide prevention, and thus the mental health care of young people, still requires further articulation and exploration. The limited research that has been conducted has demonstrated child and youth care workers' roles in mental health and suicide care as the professional in-between (Ranahan, 2013a), whereby youth workers often serve as a referral agent rather than care provider. Rickwood and Mazzer (2011) articulate the role for youth workers as the "gateway providers" or facilitators of a young person's "pathway to mental health care" (p. 5). Yet emerging research on mental health literacy (MHL) and youth help-seeking preferences have established a need for closer examination of the role and process of youth worker engagement with young people who may be experiencing mental health concerns.

The purpose of this paper is to articulate the current role of youth workers in mental health care, examine emerging perspectives in research and education on MHL development, and propose directions for education and research in this area. First, explore the current role of youth workers in mental health care from both insider and outsider perspectives located within the literature. In examining

this role, we also draw upon the help-seeking literature that provides information on young people's preferences for obtaining support when struggling with mental health related concerns. Second, because youth workers' MHL is important in delineating their role in the provision of mental health care, we describe and critique the traditional, standardized approaches to investigating and enhancing mental health literacy. Thirdly, we discuss directions for future research and MHL education for youth workers and suggest areas that require inquiry so that youth workers can move beyond pathway facilitators or being in-between. Thus, through increased understanding, youth workers can take up the position of collaborative partners with young people, families, and allied professionals in providing mental health care. This is the first paper that we are aware of to take up a critical examination of the role youth workers have in the provision of mental health care.

The Current Role of Youth Workers in Mental Health Care

To date, there has been limited discussion within the youth work profession and academic conversation on the function and capacities of youth workers providing mental health care. Current discussion has ranged from dismissal of a psychiatric approach in which an individual's diagnosis and treatment guidelines steer practice (Fewster, 2002), to a focus on the physical proximity of youth workers to those who are most vulnerable (e.g., Bourke & Evans, 2000; White, 1996). Perspectives from within and outside the field of youth work on the role of youth workers in mental health care need to be considered, including what young people themselves are voicing about their preferred sources for help.

What is Youth Work?

Youth work and child and youth care practice have been discussed within the field as an approach or designation (Vachon, 2013). Professionals utilize a therapeutic approach in providing relational interventions with children, youth, and families that serve to promote development and well-being (Vachon, 2013). Relationships are not only therapeutic, but also educative in providing experiential opportunities for young people to engage with others and learn skills in supportive relationships (Rodd & Stuart, 2009). Anglin (1999) posits that the philosophy underlying child and youth care practice is what distinguishes the profession from other roles within the helping field. He maintains that child and youth care is orientated towards personal change, viewing development holistically, with a focus on relationship. The relationship with young people is viewed as voluntary even in situations where an individual has been mandated or required by programs or systems to have a youth worker involved (Merton, 2004). In such circumstances, youth workers are often able to negotiate how the relationship is constructed via activities involved and how support is offered and received (Merton, 2004). Further, youth workers view young people in a holistic manner, and not solely focused on one particular issue or need (Anglin, 1999; Merton, 2013). Thus, youth work

may be viewed as an interactive and multifaceted process (Davies, 2010). This brief overview is an insider perspective on youth work. In relation to the provision of mental health care, those outside the profession are defining youth workers as gatekeepers—a role that requires further discussion.

Youth Workers as Gatekeepers

Rickwood, Deane, and Wilson (2007) posit that youth workers, alongside school counselors and general practitioners, may be the “most likely to act as gatekeepers to mental health services” (S35). The position and proximity of youth workers to those young people who may be most vulnerable are often touted as the rationale for identifying youth workers’ role as gatekeepers (Bourke & Evans, 2000; Cartmill, Deane, & Wilson, 2009; Wright & Martin, 1999). Yet there is a paucity of mental health and suicide content in preservice education (Ranahan, 2012). Suicide prevention efforts in particular have often identified a gatekeeper role in identifying persons at risk for suicide and linking the person to mental health care. Several mental health and suicide educational programs described as gatekeeper training are based on the premise that those at risk of suicide or mental health problems often exhibit signs of needing help to others. Such educational programs are designed to increase participants’ self-confidence in suicide intervention, recognize warning signs, increase knowledge of mental health services available (Burns & Patton, 2000), reduce stigma associated with help-seeking, and promote organizationwide awareness of mental health and suicide (Mann et al., 2005). Standardized gatekeeper training programs, such as Mental Health First Aid (Jorm, Kitchener, Kanowski, & Kelly, 2007) or Applied Suicide Intervention Skills Training (LivingWorks Education Inc., 2007), are provided over 1 to 2 days and generally include pedagogical approaches such as lectures, role playing, video demonstrations, and group activities. Short interventions have raised concerns regarding retention of learning over time (Chagnon et al., 2007). Further, a short education program may limit the potential and capacity for youth workers to play a more significant, collaborative role in mental health care with young people. Defining the role of youth workers as gatekeepers who provide brief training programs limits the role of youth workers in mental health care. Vachon (2013) asserts, “Gatekeeping is about controlling access. Gatekeepers determine what is, and is not, allowed to enter” (p. 169). As such, youth workers are positioned merely at the doorway, facilitators to other service providers, waving young people through but not accompanying them to the other side.

Youth Preferences for Help

When referrals to traditional mental health care providers are suggested to young people, youth workers report that young people respond with “no, what I want is you” (Rodd & Stuart, 2009), or question why helpers are called upon to assist them, even in situations involving suicide, when they view the youth workers

as those who could help (Ranahan, 2013a). Young people prefer help from family, close friends, or partners when facing emotional problems or experiencing concerns about their mental health (Booth et al., 2004; Burns & Rapee, 2005; Ciarrochi, Wilson, Deane, & Rickwood, 2003; Gilchrist & Sullivan, 2006; Jorm, Wright, & Morgan, 2007). Young people want to speak to caring, nonjudgmental, supportive, and genuine people with whom they have an existing relationship (Boyd et al., 2007). Further, young people require encouragement and a positive attitude about seeking help from others (Guliver, Griffiths, & Christensen, 2012). Therefore, drawing on young people's desired characteristics of helpers, young people's requests for youth workers to be the ones to help, and the youth work profession's relational orientation to practice, youth workers' role in mental health care should extend beyond gatekeeping status to collaborative partners with youth, their families, and other service providers.

Youth Workers as Collaborative Partners

Emerging efforts to encourage a collaborative approach among service providers of mental health care are evident (Thomas & Hargett, 1999). Collaborative mental health care refers to mental health service providers of different disciplines, including family medicine, psychiatry, psychology, social work, and nursing (Mulvale & Bougeault, 2007). Collaborative mental health professionals are encouraged to establish partnerships with families receiving mental health services in all aspects of intervention, treatment, and evaluation of services (Huang et al., 2005). Manion (2010) posits that professionals' attitudes must be adjusted "whereby young people themselves are not viewed simply as recipients of care but as partners in care" (p. 55). In this transformation of care from families and young people as service recipients to collaborative partners, a new consideration emerges of how the mental health professional is positioned in relation to the individual (Jobes, 2006). Jobes (2006) designed a suicide risk assessment that emphasizes a collaborative approach with the mental health professional physically positioned alongside the person-at-risk instead of sitting in front of the person behind a desk or with a notebook in hand. Such positioning is an important literal and symbolic move for the professional from a distant expert to a collaborative partner. This collaborative physical stance is philosophically aligned with youth work practice in the development of therapeutic and educative relationships with young people and the perspective that such relationships are central to practice (Rodd & Stewart, 2009), and the context in which intervention and change occurs (Stuart, 2009). Though youth workers become partners in the provision of collaborative mental health care with young people, it is not clear what mental health knowledges and practices are required of the youth workers for their full participation in young peoples' care. Kutcher, Davidson, and Manion (2009) state that there is a "growing realization that mental health care competencies, not professional identification, should define roles and functions of mental health care team members" (p.

315). Thus it is important to consider how MHL is currently understood, examined through research, and enhanced through education with the aim of identifying and strengthening youth workers' role and function in mental health care.

Developing MHL

Jorm et al. (1997) defined MHL as "knowledge and beliefs about mental disorders which aid their recognition, management, or prevention" (p. 182). As this concept has been developed, a customary approach to research has been adopted and so have standardized methods of training and programming. However, innovative experiential programs are also being used to understand and increase MHL. The following is an overview of literature specific to the MHL of youth and those who work with youth.

Customary MHL Research Approaches

Current research on MHL is primarily comprised of quantitative studies and tends to focus on measuring levels of declared knowledge, attitudes, and awareness of resources among both youth and those who work with them. For instance, large-scale surveys have been conducted in both Canada and England to assess young people's recognition of depressive symptoms and their perceived barriers and facilitators to help-seeking (Kids Help Phone, 2010; Klineberg, Biddle, Donovan, & Gunell, 2010). These factors are measured by providing a vignette, or a series of vignettes, portraying a young person who is showing symptoms of mental illness with varying degrees of severity. For example, the following vignette used by Olsson and Kennedy (2010) depicts symptoms of depression in a young person:

> Jenny is a 15-year-old girl who has been feeling unusually sad and miserable for the last several months. She is tired all the time and has trouble sleeping at night. Jenny doesn't feel like eating and she has lost weight recently. She can't keep her mind on her studies and her grades in school have dropped. She puts off making decisions and even day-to-day tasks seem too much for her. The people who know her are very concerned about her (p. 293).

This same style of vignette has been used by a number of researchers. The details such as gender and age may be altered depending on the target population under study, but the overall theme and symptoms are similar. To illustrate, in the study conducted by Klineberg et al. (2010), the survey was divided into two sections. The first depicted a fictional person with mild to moderate symptoms of depression and anxiety; the second section described clinical depression. Participants were asked to identify signs of mental health issues and discuss their reactions to the hypothetical situations. While the majority of respondents were able to identify symptoms of severe depression, the results showed a significant gap

between intentions and actions. Many respondents suggested that a person with mental health issues should see a doctor, yet few believed that the person would actually seek help.

Other studies have taken a more specific approach by identifying a particular barrier to help-seeking around mental health issues and investigating further. In a study conducted by Bowers, Manion, Papadopoulos, and Gauvreau (2012), young people's perception of stigma was compared to that of school-based service providers. The researchers found that the young people in the study were more likely to consider stigma as a barrier than the service providers.

The same method of relying on large-scale vignette-based surveys was used to investigate MHL for those working with youth, in particular, educators (Daniszewski, 2013; Masillo et al., 2012; Reavley, McCann, & Jorm, 2012). The intended outcome was to evaluate teachers' levels of declared knowledge, awareness of available resources, comfort level with mental health issues, and interest in improving their MHL. Results showed that while many educators were able to identify symptoms of mental illness in students, many were unaware of available resources and unfamiliar with mental health legislation. However, there was a high level of interest in continued learning about mental health issues (Daniszewski, 2013; Masillo et al., 2012).

For youth and those working with youth, the customary approach to determining MHL has been based on assessing current levels of knowledge in a quantifiable manner. Large-scale surveys are the dominant method relied upon to reveal gaps in declared knowledge that can then be addressed in MHL educational programs.

Programs to Improve MHL

Aligned with the dominant research procedures reviewed above, much of the current educational programming on MHL is focused on increasing levels of declared knowledge and awareness among youth and those who work with youth. However, increased levels of knowledge do not necessarily impact barriers and facilitators to youth help-seeking. For example, Pinto-Foltz, Lodgeson, and Myers (2011) evaluated the short- and long-term effects of a ten-week knowledge-contact program for adolescent girls, In Our Own Voice. The researchers concluded that while the level of MHL increased, there was no change in the perception of stigma around the issue of mental problems. Pinto-Foltz et al. (2011) stated that the findings "illustrate a potential disconnection between thoughts and feelings" (p. 2017). This indicates that MHL programming cannot focus solely on mental health education; it is necessary to take steps towards decreasing barriers to help-seeking as well.

Youth-serving professionals who are designated as gatekeepers are often provided with standardized educational programs to address MHL. Wei, Kutcher, and Szumilas (2011) proposed a model of school-based interventions for which it is

necessary to train teachers. They argued that such a method would "ensure quality and sustainability through evaluation of desired outcomes such as changes in knowledge, attitudes, help-seeking behavior, referral processes, referral outcomes, and ongoing collaboration" (p. 224). Similar programs have been shown to increase participants' knowledge about depression and suicide. Furthermore, this program provided gatekeepers with contact information for local resources, which targeted the previously mentioned issue that many educators were not aware of referral options for youth with mental health concerns.

Outside school-based interventions, one of the most commonly used training programs in Canada is Applied Suicide Intervention Skills Training (ASIST). This two-day intensive program trains participants to recognize when a person is at risk of suicide, to intervene with that person, and to refer them to appropriate services. Recently, Sareen and colleagues (2013) conducted a study on a First Nations Reserve comparing the impact of the ASIST program to that of a Resilience Retreat, which focused on strengthening communities rather than suicide prevention. The two programs did not show any significant difference in one's capacity to intervene with suicidal behavior. The researchers concluded that "The lack of efficacy of ASIST in a First Nations on-reserve sample is a concern in the context of widespread policies in Canada on the use of gatekeeper training in suicide prevention" (p. 1).

Despite the lack of clear evidence that these programs shift MHL over time, such programs continue to be offered to other professionals in the healthcare field. In a study to investigate the impact of a MHL program for nurses, researchers discovered that the value of the experience was the process of sharing knowledge and workplace experience, as opposed to actually increasing MHL (Joyce et al., 2011). Such results indicate that while MHL educational programs may have prespecified intended outcomes, participants may place a higher value on experiential aspects of the program. This suggests incorporating a more experiential approach to enhancing MHL may be warranted.

Experiential Programs

In contrast to the standard MHL programs, a small number of individualized, experiential programs have been developed in order to target the needs of particular groups and communities. A more holistic approach to MHL educational programs would be beneficial as evidenced by a study conducted with Aboriginal mental health workers (Nagel, Thompson, Robinson, Condon, & Trauer, 2009). Researchers concluded that the use of metaphors, local people as educators, inclusion of pictures and artwork, and a more strengths-focused approach were beneficial strategies for enhancing MHL. Furthermore, theater has been shown as a useful medium for arts-based programs designed to disseminate mental health information and reduce stigma. A study conducted by Blignault et al. (2010) analyzed the impact of this strategy and found that audience members showed a

positive attitude towards people with mental illness as well as a greater use of mental health services. Koh and Shrimpton (2013) discuss another strategy using an art exhibition by people who have experienced mental illness. This strategy was shown to be highly effective in helping others understand mental illness, sympathize with those suffering from mental illness, and appreciate the creativity of those with mental illness.

As mentioned above, Sareen and colleagues' (2013) study compared the ASIST program to a Resilience Retreat. The Resilience Retreat, conducted over two days, included cultural activities, sharing circles, group discussion, and storytelling. Rather than focusing exclusively on suicide education and awareness, the Resilience Retreat approach was to build resiliency in youth and the community at large. The researchers found that despite the fact that the program did not focus on suicide prevention specifically, the outcomes were much the same as the ASIST program. Furthermore, the Resilience Retreat was developed by members of the community themselves, making the experience contextually specific and culturally relevant to the participants. Such considerations are essential to the efficacy of MHL programs. Participants can understand and relate to the content in a way that is meaningful to them.

Critique of MHL Educational Programs

The implementation of programs to enhance MHL is viewed as an important step in suicide prevention and mental health care. The standardized programs offer people an opportunity to increase their knowledge about mental health, learn to recognize symptoms of mental illness, and raise their awareness of how to deal with mental illness, either in themselves or in others.

However, within standardized MHL programs, such as ASIST, there is a prevalence of treating recipients all the same. The same knowledge and training is offered regardless of culture or context. White and Morris (2010) argue that the evidence-based curricula of standardized programs "authorize expert knowledge to the exclusion of all other ways of knowing, locate problems inside persons, make no room for uncertainty and ambiguity, inhibit local and relational meaning-making, and stifle creativity" (p. 2193). These programs do not take into consideration the different kinds of knowledge relevant in differing contexts. There is a limit to what they can achieve. Furthermore, there is a gap between intention and action. Even if persons are aware that they should seek help, it does not mean that they will. An increased level of education on mental health issues does not necessarily decrease barriers to help-seeking.

MHL programs using experiential strategies are not widespread, and there is little research available as to the impact of such programs on MHL and how this in turn supports the mental health of young people. Furthermore, those that have shown positive outcomes are individualized programs, and thus, further examination of them is needed. The initial feedback has been positive. These programs

not only educated participants on the subject matter, but were also effective in reducing stigma, which is a major barrier to help-seeking. For example, Nagel et al. (2009) noted having prominent community members speak about their own struggles with mental illness in order to encourage others to openly discuss their own. This approach allowed participants to speak and receive information in a language that is familiar and resonates with their own experience. Such experiential approaches are relational, and emphasize participation—features that are congruent with the philosophical and practical application of youth work. In order to articulate the role of youth workers in the provision of mental health care and how MHL may be conceptually understood and enhanced, more research is needed.

Future Research Directions

Relationships are viewed as central to youth work practice, or "the glue that holds our work together" (Rodd & Stewart, 2009, p. 4). It is a relationship of service whereby the youth worker is committed to prioritizing young people's interests, working towards transforming the social context and youth within it (Sercombe, 2007). Child and youth care professionals described being with a young person experiencing suicidal thoughts as a key action within the intervention (Ranahan, 2013b). Further, young people are saying they prefer to have a personal relationship with a provider for mental health concerns (Boyd et al., 2007). Such relationships are "no longer a connectivity where solutions flow to the problem; it is instead one where the relational context is shaped by the collision of identities, realities, and imaginations that merge into complex and ultimately unpredictable outcomes" (Gharabaghi, 2008, p. 31). Thus, relationships are experiences occurring within an interactional context and require innovative, qualitative examination.

Just as the development of MHL programs has begun to include experiential elements in educational and mental health promotion programs, the focus of research must include qualitative examination of how MHL is enacted and constructed in context. Kutcher and colleagues (2009) posit that education and monitoring are required for primary health care teams to be restructured to include youth work professionals, and Cartmill, Deane, and Wilson (2009) maintain that future research needs to examine youth workers' process of helping young people seeking help in more detail. The following are examples of inquiry into how MHL may be used and how language is a factor in localizing MHL.

Examining Process

A qualitative research method, grounded theory, can be valuable for exploring social or interactional processes (Maijala, Paavilainen, & Astedet-Kurki, 2003), such as youth workers' interactions with young people and other professionals in providing mental health care. This allows the researcher to generate theories that explain human behavior as it occurs within a social context (Wuest, 2012). Theory development is the explicit goal of grounded theory research such that the

researcher moves beyond description of the phenomenon under study "towards a theoretical rendering that identifies key explanatory concepts and the relationships among them" (Wuest, 2012, p. 226). For example, asking youth workers to explain their experience with suicidal adolescents or discussing implementation of suicide intervention protocols can result in producing a practical and relevant theory of how youth workers make use of MHL in practice. Theories will provide knowledge for making suggestions for changes and areas of improvement for the future in youth work practice and education in mental health care. Further, a grounded theory approach requires seeking out more than one data source (Schreiber, 2001), which is a highly relevant means of exploration for examining the youth work profession in mental health care practice as youth workers may engage multiple persons (e.g., supervisors, psychologists, youth, peers, teachers, foster parents, or family members) in caring for an adolescent. Further, in a grounded theory approach, data collection and analysis occur simultaneously and new data is compared to data collected at earlier points in the research (Charmaz, 2006). For example, data collection may begin with interviews with youth workers, and analysis of these interviews may suggest that young people's voices must be added to the analysis of what is happening in mental health care. Focus groups with young people who have received mental health care may follow, and data from young people (e.g., how young people experience the process of mental health intervention) may be compared with youth workers' perspectives. Through such constant comparison, identification of patterns, emerging explanations, and depiction of the interactional process in visual diagrams, an integrated theoretical framework emerges of how youth workers provide mental health care and how MHL is used and constructed in context (Gibbs, 2007).

Examining Language-In-Use

Communication is a key aspect of current conceptualizations of MHL. For example, youth workers may use different communication techniques (e.g., open questions) to engage youth in discussions about their observations of youths' changes in affect or energy level, communicate verbally or through documentation their observations to other professionals and family members, or youth workers may read, interpret, and apply various texts such as agency protocols or suicide intervention checklists with the youth during an interaction. This language is used in all forms of communication constructs and supports. It may also impede the interaction between youth and youth worker. As such, discourse analysis is a well-suited method to explore MHL in the context of youth worker-youth interactions. Gee (2012) states, "Literacy practices are almost always fully integrated with, interwoven into, constituted as parts of, the very texture of wider practices that involve talk, interaction, values, and beliefs" (p. 374). Further, "language both mediates and constructs our understanding of reality" (Starks & Trinidad, 2007, p. 1374). Discourse analysis can address the contextualized role of discourse in shaping social relations and sub-

jectivity in which experiences occur that is often ignored in circumstances involving mental health (Crowe, 2000). By describing how language-in-use (e.g., sentences, utterances) are meaningful in the context of youth workers-youth communication, inquiry will advance current knowledge of youth workers' discursive use of MHL in practice. Analyzing discourse "contributes to our knowledge and understanding of the various social and clinical activities that take place in [youth work] settings" (Harvey & Adolphs, 2012, p. 479). It also contributes to "the role discourse plays in conveying and shaping individuals' personal experiences" of practice with youth experiencing mental health problems (Harvey & Adolphs, 2012, p. 479). Data analysis based on Gee's (1999) set of 27 questions "about how language, at a given time and place, is used to construe the aspects of the situation network as realized at that time and place and how the aspects of the situation network simultaneously give meaning to that language" (p. 110). The analysis addresses questions such as, "What are the situated meanings of some of the words and phrases that seem important in the situation?" and, "How are identities stabilized or transformed in the situation?" (Gee, 1999, pp. 110–111). Another question, "How are youth workers' identities as gatekeepers constructed through language used by youth workers and other professionals in the context of providing mental health care?"

Despite the importance of communication in youth work interactions and current conceptualizations of MHL, there is limited research in the discourse of this specific area. However, current research demonstrates the importance of inquiry into how language may limit or construct perceptions of mental health or illness.

Gladstone (2012) examined a MHL group intervention with children of parents with mental illness, completed a discourse analysis of the program manual, and explicated the language conveyed actively constructed knowledge and beliefs about mental health. However, the medicalized language and biomedical explanations of mental health were found to be inadequate in describing the children's experiences. Gladstone concluded that different knowledge, including children's knowledge, should be taken into account in determining good MHL.

White and Morris (2010) used a discursive critical constructionist methodology to examine a school-based suicide prevention program. The program followed a traditional approach whereby the focus was on teaching students information about suicide such as risk factors. The researchers found that concepts used in suicide educational programs could be deemed stable or viewed as "universalizing terms that transcend time and context" (p. 2187). They found the language used in the program excluded multiple ways of knowing about mental illness and suicide and therefore limited creativity and made "no room for uncertainty or ambiguity" (p. 2194) for the suicide educators and youth participants. Such findings indicate the limitations of the language used in current educational efforts to address MHL.

O'Reilly, Taylor, and Vostanis (2009) analyzed the discourse of homeless youths' perceptions of mental illness, which revealed that young people are resistant to engaging in services that are deemed mental health services. For example,

a participant in the study distinguished between a worker's title of mental health coordinator and her perception of and relationship to the worker. Despite the young person seeing the worker, she denied any mental health need or problems, thus suggesting resistance to the term "mental health." Further, O'Reilly et al. assert that "exploring the discourses of mental health, and investigating in depth the ways in which people construct the concepts and apply them to their lives, is an important step in advocating change" in deconstructing the stigmatization of mental illness in society (p. 1743). The language used by youth workers in mental health practice then can be influential on a young person's engagement. What language do youth workers use with youth in situations involving a mental problem? What terms, concepts, and definitions construct their experience and thus influence the construction of the contextualized interaction? Such questions remain unanswered and require further inquiry.

Discourse analysis and grounded theory methodology may address issues and questions currently unanswered in regards to youth workers' providing mental health care to young people. Understanding the process of MHL in an interactional context and the language-in-use by youth workers and youth will undoubtedly extend our knowledge of youth workers' role in interactions and how MHL educational programs for this professional population may be enhanced. Such methodological approaches are aligned with youth work practice, which is relational and contextualized. Traditional research approaches using vignettes as a means of examining MHL are not well-suited to the complexities and relational process-oriented approaches of youth work practice in mental health that encounters serious problems such as suicide (White, 2012).

Conclusion

Youth workers have a role in caring for young people experiencing mental health concerns. The nature and function of the role of youth work within mental health, as it is currently defined, is limited to a referring professional or gatekeeper on the path to formal mental health services. The construction of this gatekeeper role has been supported and sustained by current efforts in MHL research and education. The present methodological approaches are not able to illuminate the complexities of the youth worker-youth relationship process, and MHL education is provided in time-limited workshop formats, thus hindering the capacity of youth workers to respond in a meaningful role. Efforts to advance knowledge must include qualitative research approaches, such as grounded theory method or discourse analysis. The role and process of youth work in mental health care needs examination, and innovative strategies to enhance the capacities of youth workers through MHL curriculum design and education need development. Young people are asking why youth workers are referring them to other service providers. It is time to hear and respond to their query.

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