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Recommendations to Practitioners for Adolescent Clients with a History of Trauma

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CE 695 Capstone Project

Abstract

Children and adolescents who are exposed to traumatic events are at higher risk for developing mental health disorders over their lifetime. Therefore, this paper explores the effects of abuse and trauma in children and youth and aims to promote implementation of trauma-informed care principles with practitioners who work with at-risk youth. Specifically, this paper identifies the barriers that affect clients with a history of trauma and provides recommendations such as Positive Youth Development, Mentoring, and Day Treatment to practitioners who work with this population. In addition, the impact that day treatment programs have on degree of impairment and functioning for children and adolescents will be discussed. Multiple services such as utilization of mentoring programs and aftercare recommendations can be effective and influence a youth's outcome in areas of academic, emotional and behavioral problems. Barriers to treatment integration of trauma-informed care practices for practitioners who work with at-risk youth will also be discussed.

Recommendations to Practitioners for Adolescent Clients with a History of Trauma

Most states recognize neglect, physical abuse, psychological maltreatment and sexual abuse as the four major types of abuse to children.

Child abuse and neglect is defined as: Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm (U.S. Department of Health and Human Services, [USDHHS] 2014).

In 2013, an estimated 679,000 children in this country were victims of abuse and neglect (Child Welfare Information Gateway, 2015). Past studies have shown that many of these same children are victims of other forms of trauma that include exposure to domestic violence, parental substance abuse, and traumatic events in the community. Compounding traumatization in youth results in a greater prevalence of mental health problems when compared to the general population (Kramer, Sigel, Connors-Burrow, Savary, & Tempel, 2013). The increased rates of mental health problems include disorders such as posttraumatic stress, anxiety and depression; such disorders may lead to behavioral difficulties that include conduct problems, and abuse-specific problems, problems in interpersonal relationships, difficulties in school and low self-esteem (Dorsey et al., 2012).

In the child social services system, practices such as removing a child from the home, placing a child in multiple placements in out-of-home settings, transfers to new schools, and separation from existing social support networks, may worsen the effects of the initial trauma (Kramer et al., 2013). Due to their traumatic histories combined with the additional stressors listed above, it is evident that there is a need to develop trauma-informed practices and provide treatment recommendations to child social services directors, supervisors and other workers who spend their time with these children in order to encourage healthy, positive outcomes, and

therapeutic change (Kramer et al., 2013). The purpose of this literature review is to provide recommendations and effective interventions for at-risk youth to school and mental health practitioners for clients with a history of trauma.

Child Social Services System

The child social services system encounters the highest percentage of children with a trauma history; it also serves children that have experienced at least one major traumatic event with many having long and complex trauma histories (Ko et al., 2008). Treatment or Therapeutic Foster Care (TFC) is an out-of-home treatment for children and adolescents with these complex trauma histories, and often presenting with emotional and behavioral problems. Treatment Foster Care differs from traditional foster care as it is treatment-based, and the parents are therapeutic agents who are responsible for working with other professionals on a multidisciplinary team (Dorsey et al., 2012). The majority of youth in TFC and residential treatment settings (e.g., group homes, inpatient settings, and more restrictive out-of-home care settings) has been exposed to trauma that includes child abuse and neglect, which leads to implications across the lifespan and into adulthood (Dorsey et al., 2012). Therefore, TFC teams must have a clear understanding of trauma and the impact on the mental health of placed youth.

The prevalence of mental health problems is higher in services such as foster care where children often present with complex trauma histories and behavioral and/or emotional problems (Ko et al., 2008). These problems are often unrecognized, and even when discovered, many geographical areas lack trauma-informed service providers who are experts in evidence-based treatment for traumatic stress disorders (Ko et al., 2008). Dorsey et al. (2012) discussed that treatment providers or foster parents are often the least informed about exposure to sexual abuse

and domestic violence of a child's trauma exposure history. Sexual abuse and domestic violence are two types of trauma with the fewest research-supported treatments.

Barriers Affecting the Completion of Trauma-Focused Treatments

One barrier relates to determination of therapy needs of the adolescent. Determining the necessary length of treatment is important. Sprang et al. (2013) discussed how therapeutic effects are better achieved when children and caregivers participate in treatment for the least minimum prescribed time. The authors discussed how premature dropout rates were a significant problem in the field of child psychotherapy. The authors conducted a study to evaluate the impact of child and family characteristics, problem type, and trauma type on dropout rates in traumatized children who receive trauma informed evidence-based practices.

In addition, another barrier for treatment is an incomplete trauma history of the client. Sprang et al. (2013) obtained trauma history information from reports from the children/adolescents, parents/caregivers, and other relatives. The history was periodically updated and new information was added as it was learned or obtained throughout the study. The trauma history included a list of trauma, loss and separation exposures that included the following: sexual maltreatment/abuse, sexual assault/rape, physical abuse/maltreatment, physical assault, emotional abuse/psychological maltreatment, neglect, domestic violence, war/terrorism/political violence inside the United States, war/terrorism, political violence outside the United States, illness/medical, injury/accident, natural disaster, kidnapping, traumatic loss/bereavement, forced displacement, impaired caregiver, extreme personal/interpersonal violence, community violence, school violence, and other trauma not listed previously. In another study, McPherson et al. (2012) defined Childhood Sexual Abuse (CSA) as a child who participates in sexual activities beyond their comprehension, who is developmentally unprepared and unable to give informed consent, or who has been exposed to pornography or has been

subject to child pornography. Hence, it is important to continually re-assess clients to add information about their trauma as it is shared with practitioners, as well as to recognize all types of trauma that could affect clients.

Non-completion or Low Attendance. There are various factors that contribute to non-completion or low attendance among clients and families involved in treatment. Sprang et al. (2013) found that children who did not live with biological parents and who were involved in social services such as state custody or lived with a relative in an out-of-home placement were more likely to complete treatment. One explanation for this is because all children who are in state custody receive Medicaid coverage, which pays for services. Another explanation could be because services are often monitored for compliance by the state agencies or the legal system. One barrier to services is affordability of mental health services and not all parents have the means to pay. McPherson et al. (2012) noted that the following groups were more likely to continue services beyond the first session: a) white, school-aged children, b) families that had access to a telephone, c) victims referred to a private center, d) children in families where the mother received treatment needs for the whole family, and e) children who were placed in foster care. However, questions have been addressed about the longevity and stability of therapeutic gains when they are mandated and monitored by external structures and agencies (Sprang et al., 2013). External agencies such as child protective services might improve drop out rates in the short-term, but not much is known after service providers are no longer involved and treatment is no longer mandated in the long-term (Sprang et al., 2013).

Demographic Factors. Race was another factor that the authors addressed with dropout rates. Children who were not Caucasian were 57.5% more likely to drop out of services than Caucasian children (Sprang et al., 2013). McPherson et al. (2012) determined that minority status,

lower education level, low income, caregiver's perceptions of the therapeutic relationship between the client and therapist, financial stressors due to the cost of service, and less severe or chronic abuse were significant barriers to successful completion of treatment. African American children were more likely to drop out than children of other racial groups, which was also consistent with other treatment outcome literature (Sprang et al., 2013). Some reasons for this outcome include the failure of the clinician to build rapport and engage with the family, lack of resources for the family to attend therapy, the tendency for preference for informal sources of assistance, and African American families' placement of mental health needs as a lower priority than others (Sprang et al., 2013).

Other studies have found that lower socioeconomic status (SES) contributes to negative utilization of mental health services; McPherson et al. (2012) discussed how past research has indicated that families with lower income are not as likely to utilize services because of cost. However, when it came to their own research, McPherson et al. (2012) did not find a significant difference in participation among families with lower SES. They concluded that billing procedures and funding sources contributed to this finding because they utilized a sliding fee scale according to a family's income level (McPherson et al., 2012).

Oppositional Defiant Disorder was found to be a significant predictor of dropout while Generalized Anxiety Disorder was a significant predictor of treatment completion (Sprang et al., 2013). Depression did not have any significance in relation to dropout rates. The authors hypothesized that a high level of "goodness of fit" between the child's presenting problem and the clinician's expertise was crucial for treatment to be effective and for dropout to not be an issue (Sprang et al., 2013).

Willingness of Parental Involvement. Sprang et al. (2013) discussed the importance of parental motivation to the completion of treatment. Low rates of parental engagement result in treatment dropout, which plays an even more significant role than the child's psychological condition (Sprang et al., 2013). McPherson et al. (2012) determined that completion of therapy was dependent on the caregiver's level of participation as well as if the child/family received a referral for other mental health services to continue post treatment. According to Sprang et al. (2013), parental motivation may be affected when parents experience negative self-attributions for their children's therapy. In other words, they may experience self-blame and negative feelings about their parenting in relation to their child's need for treatment services. Along with self-blame, the parent may experience distorted beliefs that they are responsible for their child's injury or did not do their job to protect or save them from the abuse or danger (Sprang et al., 2013). A parent's emotional reaction to the abuse and their own mental health issues can influence treatment outcomes as well (McPherson et al., 2012). A parent who participates in their child's treatment may trigger their own trauma history, which can make their child's therapy painful and difficult to experience. In turn, parents may avoid or leave therapeutic services in order to avoid reliving their own traumatic experiences. McPherson et al. (2012) found that when caregivers participated in counseling services, the patient was more likely to successfully complete treatment. Parents and caregivers level of compliance was crucial for treatment recommendations to be successful and for the family to be motivated to participate in the treatment and provide support for their child (McPherson et al., 2012).

Systemic Factors. At-risk youth have complex needs and typically utilize multiple service systems that may include child welfare, mental health, special education, juvenile corrections, and others as needed (Sanders, Munford, Liebenberg, & Ungar, 2014). Despite

having access to an abundant amount of services, these youth do not typically achieve better outcomes (Sanders et al., 2014). Multiple service use is associated with higher risk; past literature has found that youth who are involved with justice services have a high risk of conduct disorder or comorbid mental health concerns (Liebenberg & Ungar, 2014). Risk can be offset in some areas if protective resources are available in one area of the youth's life (Sanders et al., 2014). Use of multiple service systems has been observed to increase risk and attribute to poorer outcomes (Sanders & Munford, 2014).

Recent research has indicated that resilience and positive outcomes are reached when at-risk youth report that service providers were respectful, provided an opportunity to demonstrate personal agency, or encouraged them to be active members in solving their issues or challenges (Sanders et al., 2014). When at-risk youth are active team members, they are able to form positive relationships with staff, be active members of a decision making process about interventions and programs, which results in more positive outcomes (Sanders & Munford, 2014). Overall, positive experiences with the people providing the services contributes to higher resilience with at-risk youth (Sanders et al., 2014). All interventions are important, but more importantly, service providers must be consistently respectful and empowering in order to ensure positive outcomes for at-risk youth (Sanders et al., 2014). Engaging caregivers in their child's treatment and providing support and intervention skills for the caregivers will significantly increase the likelihood of positive outcomes for the child (McPherson et al., 2012).

Programmatic Interventions for Youth with a History of Trauma

There are many issues that have contributed to the need for practitioners to develop and utilize effective interventions with children and adolescents with a history of trauma. The barriers listed above included low attendance, demographic variables, parental involvement, and

systemic factors. These barriers have all contributed to the prevalence of mental health problems. While it is important to note these factors, it is even more important to identify effective interventions for practitioners to adopt when working with clients with a history of trauma. The following section will discuss potential interventions such as Positive Youth Development, Day Treatment, Mentoring, and Trauma Informed Care.

Positive Youth Development. Positive Youth Development (PYD) is used with clients who are at-risk and vulnerable who utilize multiple service systems. PYD programs include the following components: encouragement of personal agency (capacity for individual to act independently), demonstration of respect to individuals and their families, and focus on an individual's strengths and competencies within the risks and challenges that these individuals may face (Sanders, Munford, Thimasarn-Anwar, Liebenberg, & Ungar, 2015). The PYD approach redefined trauma in adolescence so that individuals were not seen as problems and broken; rather they were identified as the resources to make positive change (Sanders & Munford, 2014). Using the PYD framework, the likelihood of the individual to be more successful increases when the components are positive within the use of multiple service programs (Sanders et al., 2015). Development occurs when the individuals are given the opportunity to participate in meaningful ways as well as receive positive relationship support to strengthen their capacities and abilities (Sanders & Munford, 2014). Positive relationships and autonomy are important factors in development for adolescents (Sanders et al., 2015). When PYD techniques are used the individual will be more likely to complete treatments such as day treatment or mentoring. PYD focuses on building rapport and emphasizes that respect is crucial for the individual to develop.

As previously mentioned when at-risk youth have mutually beneficial relationships and

experience services in a respected way, better outcomes are achieved. PYD has been shown to be effective with at-risk youth with behavioral issues who also experience negative exposure to neighborhood and family risks (Sanders et al., 2015). Because PYD uses a strengths-based approach to emphasize an individual's potential and looks beyond mental health to include an individual's success in school and caring for others; these individuals develop an overall sense of positive self-worth and self-efficacy (McDonald, Deatrick, Kassam-Adams, & Richmond, 2011). The components of encouragement of personal agency, respect, and focus on an individual's strengths rather than weaknesses results in the individual developing a positive self-worth in order to achieve better and more positive outcomes.

Why PYD Works with At-Risk Youth. Typically young individuals who have been exposed to abuse and neglect experience childhoods that terminate early and often must take on adult responsibility at a young age (Sanders et al., 2015). Since youth are used to responsibility, PYD begins by encouraging personal agency and respect in order for the individual to use their autonomy or newly found responsibility in positive ways; thereby, fostering resilience (Sanders et al., 2015). Second, strengths are the focus in PYD, recognizing that at-risk youth have the capacity, competence and resilience resources to use in the treatment process (Sanders et al., 2015). Third, PYD teaches a realistic view and helps youth adapt to the individual's realistic circumstances in order for the chances for the interventions to be successful (Sanders et al., 2015). Even so, PYD advocates argue that at-risk youth achieve positive outcomes and healthy development when families and neighborhoods, political, social and economic systems all work together (Sanders et al., 2015).

Comparison of Juvenile Justice to Mental Health Service Provision. Approximately 70% of justice-involved youth met diagnosis criteria for at least one mental health disorder, and

among those youth, 79% met criteria for two or more diagnoses (Dierkhising et al., 2013).

Liebenberg and Ungar (2014) compared risk of depression and engagement in treatment with youth involved in the correctional services and youth involved in mental health services. The authors hypothesized that both internalizing and externalizing behaviors would be similar to youth involved in mental health services and justice services, meaning both would have a similar risk for mental health concerns. They also predicted that justice-involved youth would have a lower rate of lifetime use of mental health services. The authors concluded that youth involved in the justice system reported lower levels of interactions with health services, mental health services and educational supports when compared to the youth involved in the mental health system (Liebenberg & Ungar, 2014).

Childhood maltreatment is associated with a greater likelihood of mental health disorders across the lifetime with the likelihood of developing Posttraumatic Stress Disorder (PTSD), anxiety disorders, mood disorders and substance abuse disorders (Dorsey et al., 2012). Forty two percent of youth are: involved in both the juvenile justice and child social services system, and report substance abuse problems and are often under the influence at the time of their arrest (Dierkhising et al., 2013). In their findings, Liebenberg and Ungar (2014) suggest and support that youth involved in the justice systems are not receiving the support they need, especially in treating mental health issues. Because mental health services are scarce in most correctional settings results of re-traumatization may lead to further issues of psychological distress (Kammerer & Mazelis, 2006). Although youth involved in the justice system may not receive adequate mental health support if they choose to utilize other services such as education, healthcare, and mental health, they will be more likely to remain out of the juvenile justice system. In sum, the authors stated that early intervention and improved mental health services

within the justice system would help facilitate better outcomes for at-risk youth (Liebenberg & Ungar, 2014).

Effectiveness of Day Treatment and Mentoring Services. Children who attend day treatment programs have begun to show significant improvement and behavior at home. Clark and Jerrott (2012) have found that children who attend day treatment programs make significant gains in treatment and improve in a variety of symptoms from admission to discharge. Even though current research has focused on the results of day treatment programs, fewer studies have assessed how well treatment effects carry into the future. Not much is known about behavior and improvement beyond graduation/discharge.

Research has indicated that recidivism occurs when an individual returns to their same environment; this environment is typically the reason why the individual was initially referred to treatment in the first place (Byers, Cohen, & Harshbarger, 1979). According to Clark and Jerrott (2012), evidence from past studies has demonstrated that theoretical strategies such as Cognitive Behavioral Therapy (CBT), parent management training, psychopharmacological treatment, and behavior techniques are effective ways of treating children and adolescents with behavioral, emotional and mental health issues. Behavioral strategies such as anger management, coping, assertiveness training, problem solving skills training and time-out are effective in the day treatment setting (Clark & Jerrott, 2012). Structured environments and living situations may provide more growth and learning opportunities for individuals to learn new behaviors and practice the coping skills they have learned while attending treatment as well as have more support at home (Byers, Cohen, & Harshbarger, 1979).

When using CBT with children and adolescents, it is also useful to include relaxation or mindfulness techniques and encourage the individuals to think of the consequences of their

behavior (Clark & Jerrott, 2012). Anger/emotional management, social skills, problem solving and compliance would be important areas to focus on. Parent training and family therapy would also be useful strategies (Clark & Jerrott, 2012). Parents should be encouraged to use the same behavior plans at home and model the appropriate behavior that they want to see from their child at home. Consistency has shown to be a very important detail to the success of the goals made (Clark & Jerrott, 2012). Parents should be trained to demonstrate positive behavior and follow the same plans at home. The use of prescribed drugs and stimulants to treat certain diagnoses would also be useful (Clark & Jerrott, 2012).

Mentoring. Youth mentoring programs pair youth with volunteers that share similar interests in an effort to build a lasting relationship that provides additional support and guidance (Schwartz, Rhodes, Chan, & Herrera, 2011). A very common and known mentoring program is Big Brothers Big Sisters. In the past two decades, such programs have experienced growth with millions of volunteers used in a youth's life (Rhodes, Liang, & Spencer, 2009). New mentoring initiatives have continued to develop and one of the newest trends is called School Based Mentoring (SBM). In SBM, mentors meet with their mentees during school hours and engage in activities such as talking, playing games, homework and reading which has been shown to encourage a youth's daily academic and social experience improving their experience and outlook on school (Schwartz et al., 2011). Improvement in areas such as academics, psychosocial and behavioral outcomes have been proven by the use of SBM (Schwartz et al., 2011). While research has shown that youth mentoring programs are effective, it is also important that mentors adhere to ethical and moral practices. Rhodes et al. (2009) identify the following examples as practices to implement in a mentoring relationship: "promote the welfare and safety of the youth, be trustworthy and responsible, act with integrity, promote justice for the

youth, and to respect the youth's rights and dignity" (p.453-456). These examples are affiliated with the ACA Code of Ethics (2014).

Practitioners' Role in Assisting Clients with a History of Trauma

Trauma Informed Care. Trauma Informed Care is a treatment framework that uses a large perspective to recognize that individuals have many different types of trauma in their lives and understand that trauma has an impact on the client, co-workers, friends, family and treatment providers (The Trauma Informed Care Project). The National Child Traumatic Stress Network (NCTSN) developed a comprehensive training curriculum for individuals who work in child social services. The goal of the NCTSN was to "raise the standard of care and improve access to services for trauma-exposed and traumatically bereaved children with their families and communities" (Kramer et al., 2013, p. 19).

Kramer et al. (2013) and Ko et al. (2008) identified nine important elements to focus on when looking into the effects of trauma on a child's emotional, behavioral, academic and social development: 1) maximize the child's sense of safety; 2) assist children in reducing overwhelming emotions; 3) help children make new meaning of their trauma history; 4) address the impact of trauma and subsequent changes in the child's behaviors, development and relationships; 5) coordinate services with other agencies; 6) utilize comprehensive assessment of a child's trauma experience and the impact on the child's development and behavior to guide services; 7) support and promote positive and stable relationships in the life of the child; 8) provide support and guidance to the child's family and caregivers; and 9) manage professional and personal stress. (p. 19-20; p. 398)

The Substance Abuse and Mental Health Service Administration (SAMHSA) identifies a program, organization or system, trauma-informed when they use the following four steps: 1)

realizes the impact of trauma and recognizes the potential paths for recovery; 2) recognizes the signs and symptoms of trauma in clients, families, staff and other individuals involved; 3) responds by integrating knowledge about trauma into their practices of their program, organization or system; and 4) seeks to avoid re-traumatization. According to Brown, Baker, and Wilcox, (2012) “trauma-informed care is grounded in the principle that treatment systems and practices should ameliorate, rather than exacerbate, the negative impacts of trauma” (p. 508). The goals of trauma-informed care include accurate identification of trauma and related symptoms, training all staff to be aware of the impact of trauma, minimizing re-traumatization, and a fundamental do no harm approach that is sensitive to how institutions may inadvertently reenact traumatic dynamics. Practitioners who use trauma-informed principles can contribute by minimizing triggers, stabilizing offenders, reducing critical incidents, deescalating situations and avoiding restraint, seclusion or other measures that may reenact past abuse (Miller & Najavits, 2012). SAMSHA recognizes that respect and collaboration are two crucial factors to promote recovery and resiliency when working with individuals.

Restraints/Hands-on Techniques. The trauma-informed care practices in adult and child treatment settings has recently become more common due to the detrimental effects of restraints and seclusions, which can lead to evidence of more trauma and re-traumatization (Brown et al. (2012). Restraints and seclusions are physical interventions used to control a patient’s aggressive or self-harming behaviors that are used when there is an imminent risk to the patient or others (E. Jackson, personal communication, January 19, 2013). In recent literature both patients and their families have considered restraint and seclusion procedures unresponsive and traumatizing and in some rare cases, deaths or severe injuries have occurred (Azeem, Aujla, Rammerth, Binsfeld, & Jones, 2011). A primary prevention principle to reduce seclusions and

restraints among youth has been used that focuses on the following: 1) establishing leadership that supports organizational change, 2) using data to inform practice, 3) implementing workforce development, 4) using of restraint and seclusion reduction tools, 5) improving consumer's role in inpatient settings, and 6) vigorous debriefing techniques (Azeem et al., 2011). A trauma-informed practitioner or individual will recognize that the results of trauma may affect more than just the individual receiving treatment. The trauma may impact other individuals that have a relationship with the victim. It will be important for treatment practitioners to recognize how their own triggers play a role in the treatment of their clients. The main goal of adopting a trauma-informed care approach is to do no harm, avoid re-traumatization, as well as to benefit clients therapeutically. It will be beneficial for treatment providers to adopt a trauma-informed care approach and remember that individuals with a history of trauma may require this type of approach in order to avoid re-traumatization.

The practitioners who work with individuals with a history of trauma have a responsibility to further their knowledge about the detrimental effects of trauma. It will be beneficial for treatment practitioners to research the negative effects of trauma and continue to educate themselves on different techniques and interventions for working with clients with a history of trauma.

Conclusion

In this literature review, negative effects of child abuse such as neglect, physical abuse, psychological maltreatment and sexual abuse were examined. This author discussed how traumatization in youth results in the prevalence of mental health problems such as posttraumatic stress, anxiety and depression. These disorders may lead to behavioral difficulties that include conduct problems, and abuse-specific problems, problems in interpersonal relationships,

difficulties in school and low self-esteem (Dorsey et al., 2012). The review also examined the barriers such as non-completion/low attendance, demographic factors, willingness of parental involvement and systemic factors that hinder the completion of treatment. Practitioners should be aware that barriers to treatment include: cost of treatment, court-ordered treatment, race, especially African American families, and parental motivation (Sprang et al., 2013). In addition, parental factors such as parental self-blame (Sprang et al., 2013), and parental willingness to participate based on their own trauma history, may be inhibiting treatment success.

In addition, several approaches for working with at-risk youth and clients with a history of trauma were addressed in this literature review. The effects of Positive Youth Development, Day Treatment and CBT, and Mentoring services were all discussed. Sprang et al., (2013) identified barriers that get in the way of working with families with a history of trauma and identified that failure to build rapport can often lead to treatment dropout and non-completion. In order to avoid this barrier, Sanders et al. (2015) discussed the importance of building resiliency by using a PYD approach to achieve positive outcomes and healthy development when families and neighborhoods, political, social and economic systems all work together. Further, PYD focuses on personal agency, encouragement and respect, and when these are successfully developed, youth are more likely to complete services and treatment interventions. Mentoring and Day Treatment services were also shown to provide gains for individuals with a history of trauma.

Furthermore, the development of a Trauma-Informed Care treatment framework was discussed due to the detrimental effects of trauma and re-traumatization. The Trauma-Informed Care treatment framework reduces triggers and re-traumatization by training and educating caregivers to recognize that trauma affects more than just the individual. Practitioners who use

trauma-informed care principles contribute by minimizing triggers, stabilizing offenders, reducing critical incidents, deescalating situations and avoiding restraint, seclusion or other measures that may reenact past abuse (Miller & Najavits, 2012). Most importantly practitioners must continue to further their learning and promote trauma-informed practices and utilize necessary resources when working with the at-risk population.

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