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Creating therapeutic relationships with disadvantaged children and youth

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Creating Therapeutic Relationships with Disadvantaged Children and Youth

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Introduction

In the four months preceding the printing of this article, the disadvantaged children and youth participating in our school-based mental health services were menaced by three life-threatening drive-by shootings that occurred while they were waiting for public transportation, twice within one block of their school-based program. One teenage client's scalp was grazed. The youth in our program were traumatized and also determined to advocate for their seven-year-old child mentees, who were walking home (alone) just ten minutes after the shooting that occurred just as school was getting out. Sadly, the young children themselves were apparently so accustomed to such experiences they thought nothing of it. What can clinical social workers contribute to remedying the profound mental health needs of children and youth in poverty? In this article, we describe clinical guidelines and case examples derived from a participatory action research process with community members struggling with profound poverty and its accompanying problems. Now in existence for four and a half years, the aim of The Empowering Counseling Program (named by the students who founded the program, inspired by the empowering approach to social work practice, Gutierrez 1998) has been to develop and implement social work interventions tailored for and with profoundly disadvantaged children and youth. Youth and community members participate in the identification of problems, service modalities, research questions, and program evaluation.

The program consists of two types of services, individual counseling and group-based mentoring programs for youth (Stand Up Help Out! and C.R.I.M.E., see

www.standuphelpout.org and *www.crimeteens.com*), provided by a team of 8 interns (B.S.W, Advanced Standing, and M.S.W. students) and after-school program instructors (the most competent interns can also earn stipends as instructors), supervised by doctoral students and alumni. The school-based interns collaborate with school social workers but do not carry out standard assessments and individualized educational plans. The interns' sole responsibilities are counseling and advocacy for the children and youth. Over the past five years we have served over 400 children in 8 schools and trained 28 interns.

Community and Children's Needs

The mental health needs of poor children and youth have, for decades, been grossly underserved (Gonzalez 2005). Problems of access, affordability, and relevance combine to produce massive social exclusion of disadvantaged children from existing services, and service providers report attrition rates of up to 60% (Kazdin 2003). When so many youth do not participate, what value can research about services possibly have? While therapeutic methods for remediating complex trauma are becoming better understood (Briere & Scott 2006; Cook *et al.* 2005), specific therapeutic guidelines are needed, especially when trauma is occurring during the time service is being provided and into the foreseeable future. Moreover, profoundly poor, urban African-American children and youth have not been sufficiently represented in most service designs and resulting research (Aisenberg 2008; Allen-Meares 2008).

Using an exploratory, participatory action approach to research (Kidd & Kral 2005; Macran, Ross *et al.* 1999), children, youth, and community members were partners in our service design and evaluation process. We began with a needs assessment

conducted with community residents. Once services were in place, children and youth evaluated their counseling services by talking with a social worker (not their counselor) about the services, and we built on their feedback. On an ongoing basis, youth in Stand Up Help Out! and C.R.I.M.E. conceptualized the problems to tackle, evaluated the services, and carried out community service projects.

We prioritized providing school-based services, because community residents were profoundly distressed about the lack of adequate educational resources and the violence to which their children were exposed while trying to be educated. The residents, often furious or in tears, described how valedictorian graduates of the local high school read at the 6th grade level and that many 10th graders did not have textbooks and had never used a computer. Teachers commented that around 4th grade students started to lose hope and became progressively more despairing about escaping poverty and its attendant violence.

Theoretical Base

Understanding the trauma children and youth experience. Using an empowerment model as a base (Guttierez 1998), we drew from two primary theories: trauma treatment theory, and self-determination theory (Ryan & Deci 2000, 2002). To apply trauma theory, first, it helps to understand the trauma children experienced. Data from nationwide studies echo residents' concerns about the community stressors: 1) under-resourced schools; 2) social exclusion and discrimination; 3) inadequate employment and training resources; 4) higher rates of reported domestic violence, child abuse and neglect; and 5) gang violence (Parke 2004; Schorr 1997; Venkatesh & Celimli 2004). In the community we serve, 97.9% of residents are African-American, 41.3% of

families are below the poverty line (compared to 9.2% nationwide), and unemployment is more than twice the national rate (according to U.S. Census data for 2000).

During school, the children are exposed to daily intimidation to join gangs and seductions to use and sell drugs and engage in other illegal activities such as child prostitution. Fighting and deeply disruptive behavior are commonplace. Unfortunately, in poverty-level families, despair and low self-esteem aggravate social isolation and exacerbate risk for mental illness and substance abuse (Shipler 2004), predisposing families to maltreat and traumatize children (Garbarino & Eckenrode 1998). Given the level of need, one would hope mental health services would be available, but such is not the case. Some 50-75% of urban children who need mental health treatment will not receive care (McKay *et al.* as cited in Gonzalez 2005, p. 246). Further, lower-income African-American youth are even less likely to receive mental health services (Bringewatt & Gershoff 2010).

Children who are exposed to multiple, long-term traumatic events, including chronic serious illness (such as life-threatening asthma) or familial abuse and neglect, generally acquire a syndrome researchers have termed **complex trauma** (Spinazzola, Ford *et al.* 2005, p. 433). Symptoms of complex trauma (Herman 2009) include affect dysregulation, impaired self-concept and self-development, disorganized attachment patterns, avoidance of situations that trigger post-traumatic distress, dissociation and numbness, intrusive thoughts and nightmares, hyperarousal, and hallucinations. Research findings demonstrate that traumatic stress is associated with memory and attention problems, and deprivation and neglect are associated with brain damage and myriad social and learning problems (Nelson, Zeanah, *et al.* 2007; Perry 2002; Saigh 1997). In a

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context of community violence, children are most likely to develop complex trauma if they are chronically ill and/or exposed to partner abuse, child physical and/or sexual abuse, or child neglect (Briere & Scott 2006). Judith Herman (2009) describes how factors producing complex trauma include a "Social structure [that] permits abuse and exploitation," including specific perpetrators of abuse and others who do not intervene to protect the victim. Perpetrators use specific relational methods--threats, "capriciously enforcing petty rules," "random intermittent rewards," isolation, and/or forcing victims into degrading or immoral acts (Herman 2009).

Our experiences led us to add to the above formulations of complex trauma. Another significant trauma for children and youth is exposure to violent and corrupt community authorities. Clients described violent police officers, landlords or housing officials whose dishonesty ruined their homes, negligent social services staff, public officials notorious for corruption, and school staff provoking fights or trying to romance youth. Further, most members of ethnic minority groups in the United States suffer from historical trauma (Ho, Rasheed *et al.* 2004). Past genocide, holocausts (the Trail of Tears), and terrorism (such as lynching) reach into the present as people can be both horrified about what happened to their forebears and transmit psychological scars from generation to generation.

Another form of trauma is the lasting threat to a personally meaningful future. Children and youth repeatedly described pictures of their futures that ranged from terrifying (death in gang violence) to tragic ("drunk like my Dad") to blank ("I can't picture it. I just know I have to try moment-to-moment"). Reacting both to the press of urgent survival needs every day, and the desperately sad conditions of many of their

elders, children and youth acquired a moment-to-moment focus and strove to ignore what felt to them to be a future full of continued danger. The very real current deprivations of adequate social supports (education, vocational skills preparation, healthy recreation) and exposure to profound dangers often confirmed that a positive future was unattainable. The damage to youths' sense of self-determination, ability to postpone gratification, and plan for their futures is obvious. As we took threat-filled presents and futures seriously, we had to alter many aspects of trauma treatment that assume the trauma is over (as occurs with adult sexual abuse survivors or war veterans, the primary populations with whom guidelines for trauma-based treatments were developed), as will be seen further below.

Guidelines Developed

To try to remedy social exclusion, we provided services in school settings. School-based services eliminate many structural barriers to services, including transportation, poverty-level caregivers' demanding schedules (those who are not disabled often work multiple and/or evening shifts), and the stigma of attending psychiatric clinics. School-based services allow counselors to be available during in-school crises, potentially reducing violence and promoting therapeutic work, and increase the likelihood of parent involvement. We accomplished this aim, as attrition rates for our Empowering Counseling Programs were 1% for the individual counseling program, and 1-14% for the youth apprenticeship mentoring program (measured over 4 years). Note that attrition does not equal attendance, as clients did miss some sessions, because they were not in school due to illness, suspension, or chaotic environments. Termination of services occurred because of the end of the school year or the after-school program, not

because the children or youth stopped coming for help. In fact, in 2010 the counseling program has a substantial waiting list of children wanting counseling help, and the mentoring program has four times more applicants than it can accept.

Modify customary trauma-focused treatment phases. The phases in trauma treatment that have been explicated (Herman 2009; van der Kolk, McFarlane & Weisaeth 1996) are, in summary: 1) to establish safety and earn the client's trust; 2) to create a collaborative, compassionate alliance so the client can observe her/his own inner life and responses; 3) to recognize and build on clients' strengths and resilience; 4) to avoid exposure to traumas or triggers (recognized as extremely difficult because traumatized persons often re-enact traumatic experiences in significant relationships, thereby re-traumatizing themselves); 5) to integrate the trauma story, which includes gradual, partial recapping of traumatic events; and 6) to heal and expand social connections. An important task of the therapist is to monitor her/his vicarious traumatization from not only the clients' story but also the distress in clients' forms of relating with the therapist.

Many of the customary steps noted above could not apply with our children and youth: We sought to but often could not guarantee their safety, nor could we do more than try assiduously (such as delegating an intern to work with the local public child welfare office to maximize their responsiveness to reports of abuse and neglect) to prevent them from being re-triggered and re-traumatized. Because clients' exposure to traumatic events and triggers for PTSD symptoms occurs randomly and continually, the intern could not stimulate traumatic memories (also called exposure) without the risk that the client would be gravely (and psychotoxically) overwhelmed. Moreover, clients continually re-write their trauma story as new events unfold. Their efforts at attaining

new goals and self-regulation can be profoundly and suddenly disrupted by fresh trauma. For example, a client whose goal was to go away to full-time college decided to try to attend part-time college from her home when her grandmother (her primary caregiver) was stricken with cancer and assaulted.

Whereas children and youth whose traumatic events are over describe them frequently to the therapist in order to master them (Sugar 1988), we found that clients whose traumatic experiences are ongoing may not want to talk about any of them for long periods of time. In fact, they often needed to feel the relationship with their social worker was a reliably peaceful oasis. They clearly made headway even if they did not discuss the traumas afflicting them.

Finally, preventing the social work intern's vicarious traumatization is more challenging, because interns faced real threats, such as when an intern was mugged on school grounds and others were menaced by a drive-by shooting. Some interns came from environments similar to those of their clients, and their own trauma was readily re-triggered. Some were from such different environments that culture shock in relating with clients and school staff was very challenging.

Enter their world and join with them completely. An intern developed this guideline to describe what she needed to do in order to help a profoundly traumatized young child. It captures the importance of creatively finding ways to help the clients understand the worker is really with them. Part of this guideline also meant taking clients' poverty and deprivation seriously. We provided ample nutritious snacks and sought to remedy other critical needs such as lack of a winter coat or pencils and paper.

One of the most difficult issues interns faced was their inclination to recommend to the children and youth that they not respond to violence with more violence. While it might seem such recommendations might reduce community violence, in fact, the clients thought the interns were completely ignorant about what the clients were experiencing and were weaklings, but generally were too polite to say so directly and instead withdrew. It was necessary to support clients' creativity about protecting themselves. Interns treated clients as experts on their own situations and asked them what they thought about how they might protect themselves (Guttierez 1998). Clients then became quite creative. For example, the after-school program youth took to leaving the program together and accompanied instructors they felt protective about (such as the one who was mugged) to bus stops at night.

Manualized* v. *nonmanualized debate: "Starting where the client is." An important debate in the field of trauma treatment concerns the pros and cons of manualized treatment approaches. Those approaches for which manuals have been compiled are primarily cognitive-behavioral and were not developed for and with impoverished African-American youth. Although manuals have the undoubted advantaged of standardizing interventions to some extent, and therefore from a research standpoint reducing some of the formidable variation in clinicians' responses, the downside is that they can reduce sticking with the time-honored social work guideline of "starting where the client is." Partly because the clients demanded it (they simply were not interested in engaging in many cognitive interventions), and also because the clients' often desperate condition made it clear that they needed, first and foremost, to feel their personal agendas and needs were respected, we found that responding to their priorities

had the most empowering and engaging impact. Social work activities included working on academic problems, listening to music, working on computers, coloring, reading, playing games and ball, using dolls and puppets, providing a couch for exhausted or ill clients to sleep on, and feeding starving clients. Frequency of sessions was generally once weekly; but for some children, such as a six-year-old who at the age of 3 had unintentionally killed two family members, sessions occurred twice weekly. While generally the interns had defined times with clients, as the structure and predictability was therapeutic for them, exceptions were made. For instance, one highly traumatized 17-year-old girl who initially made a strong connection with her social worker reacted to her mother's taunts about her involvement with therapy by becoming more resistant to attending sessions. As soon as she was allowed to set the timing of her sessions, she came once-weekly and sometimes even more often.

Client-initiated duration results in long-term treatments. Many trauma-focused treatments, especially those that are cognitive-behavioral in nature, have a specific short-term focus (around 15 sessions). Yet our clients were often, at 15 sessions, just starting to trust the social worker, and their central preoccupations were certainly not resolved. Moreover, when we knew traumatic events would still be happening to our clients, how could we justify ending their support? Our resulting guideline was never to initiate termination of a counseling process. Most clients sought care as long as school was in session, and interns' caseloads filled up quickly, and they developed waiting lists. Clients often wanted to continue counseling the following year, so many clients were seen by more than one intern, over several years. Some participated in counseling and then the after-school program, participating in our program for 3 years or more.

Accept frequent non-involvement of caregivers. Many approaches to mental health care for children understandably emphasize that the outcome of child therapy hinges on the quality of the therapeutic involvement of the parents (Novick & Novick 2005). Although in-clinic services tend to emphasize getting parents committed to services, parents in poverty often find it impossible to make such a commitment. We learned about the profound obstacles parents in poverty face in working with schools and social services (*e.g.*, shame about their own illiteracy, working several jobs), and from one principal we learned how to respond positively to even the most aggressive and potentially violent parents. Accordingly, we developed the guideline of continually seeking to support parents, but also proceeding with caring for their children if they could not actively participate in counseling.

Youth Leadership Programs:

An Accumulation of Care Model

The Empowering Counseling program focused on developing youths' strengths by providing an after-school youth leadership development program, accompanied by individual assessments that helped youth create goals, and that provided academic and vocational guidance and counseling as needed. After-school programs have significant value for improving academic performance, social behavior, and self-esteem of disadvantaged youth, especially if they include sequential programming, active learning, stable focus, and explicit goals and content (Durlak & Weissberg 2007). Since such programs tend to be most effective if they focus on youths' relationship capacities (Durlak & Weissberg 2007), we sought to develop youths' constructive relationship capacities, termed *caregiving heuristics,* or psychological structures that ground

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individuals' capacities for caring for themselves and others (McCrea & Bulanda 2008, 2010; Bulanda & McCrea, under review). The program was conceptualized as a job, so youth earned a stipend and carried out community service such as hosting a community health fair, leading a nonviolence march, and mentoring elementary school children. Working as teams on their projects, the teens reflected on their experiences in a weekly "sharing circle," and shared personal and academic concerns ranging from "favorite food" to "biggest insecurity".

Youth interviewed each other to evaluate the program and frankly talked about their concerns and priorities (Bulanda 2008). They felt most empowered by taking action to solve community problems, commenting for instance, "Everybody could come together and when we're working together and it turns out good, that's my favorite part of the program. Like when we are working on a big project and everybody puts forth effort and it turns out good, that's the best part of this program." Evidently, empowering youth to take action increases their self-efficacy, turns passive victimization into active problem-solving, develops constructive (as opposed to alienated) relationships with community members and teamwork with peers, and creates contexts in which youth will be idealized for their contributions, thus enhancing their self-esteem and images in the community. Furthermore, they could build an action-based form of hope, because they could accomplish reasonable goals (Guthrie 2011).

Youth believed the program changed their experience of caring for themselves and others. Being idealized by their young mentees was rejuvenating for them, commenting "The little kids are amazing and they are fun to help…They really love when our group works with them." They recognized that the group provided alternatives

to destructive relating and many commented they had learned how to care for children without treating them harshly. Youth were very productive, creating community forums and educational fairs, authoring video and radio documentaries, newsletters and reports, and even a book. As of this writing, the programs have been steadily funded, some youth have attended as many as five in a row, and several graduates are headed to college.

Supervision Guidelines

In contrast to some supervisory models that focus heavily on student pathology, or that adapt a triadic model of trauma theory to the supervisory relationship (Miehls 2010), we built upon the model Jane Addams developed at Hull House (Addams 1990 <1910>). From a contemporary perspective, her model can be understood as profoundly strengths-based, and this seemed most important as a way to help the interns develop and cope with the placement's stress. The most important principle we learned from Addams was to give each intern the opportunity to creatively develop services. Accordingly, each intern was asked how s/he would like to contribute to the program, and as the interns experienced the program and their clients, an individually-tailored plan was developed so they could implement their own contributions. Traditional teaching methods, such as expecting students to do process recordings and psychosocial assessments, were included. We did not require students to engage in service activities they experienced as unmanageably stressful. The great majority of interns responded to the creative freedom with enthusiasm and found it deeply meaningful to work with the children and youth. Many volunteered extra time.

In helping supervisors, the faculty leader prioritized helping interns empathize with clients, respecting interns' autonomy and developing strengths, addressing most

difficult clinical and collaborative interactions (such as reports of child abuse and neglect), and providing plentiful support to prevent vicarious traumatization. We regarded interns' distress on behalf of their deeply traumatized clients not as a pathological countertransference but as real grief at inhumane conditions. Supervisors helped interns plan attainable goals for each client so the intern understood the progress that was happening. Given the importance of parallel process, the interns' supervisors were given ample opportunity to actualize their own creative contributions to services for the children and youth, to co-author papers, proposals, service design and administrative procedures, and to carry out dissertation research. They sought to help the interns internalize two primary values: 1) devotion to (rather than fear of) people suffering grave disadvantage, and 2) respecting clients' very different experiences and the importance of helping clients create their own problem solutions (client self-determination, Guttierez 1998).

Encouraging interns' self-care was vital because of the risk of personal and also vicarious trauma. While often school staff were sources of inspiration, interns were exposed to some burned-out school staff who were hostile, negligent, or exploitative. They encountered physical and psychological risks in relation to community members, ranging from being victims of violence themselves to being solicited or robbed. Supervisors took interns' concerns seriously and helped them mourn. Most interns went through a period of deep sadness after about 6-8 weeks in the internship when they became attached to their young clients and the clients' terrible life conditions became undeniable. During this time, many wept, and we normalized that process for them so they could care for themselves and not be inhibited in devoting themselves to their

clients. Upon terminating, interns often felt they were abandoning the clients in desperate circumstances, and their grief was very real. Many responded by renewing their commitment to assist children and youth in profound poverty. The following example reflects the experiences of many interns and illustrates supervisors' priorities.

Gina was a 25-year-old, second-year social work student. Working with children suffering from complex trauma in the context of a chaotic and disorganized school was difficult, and Gina needed a lot of support and encouragement. The concept of the holding environment was helpful: The supervisor provided her with a holding environment that she in turn could provide to her clients. It was also important to help Gina create realistic goals and have realistic expectations for the progress she could expect her clients to make over the school year. While decreases in disruptive behavior in the school were desired, for some clients, maintaining their current level of disruptive behavior without getting worse was a desired outcome from treatment due to the chaotic environments the students lived in

It was also important to educate Gina about the importance of her relationship with the clients. For children who were in chaotic environments at home and school, it was helpful for them to have a relationship with an adult that was consistent and dependable. Even if the clients were angry or refused to see her, Gina came back to get them at the same time every week. She had a very high attendance rate from her clients once she showed them that she could contain their feelings of trauma and not abandon them. Gina had to mourn the many environmental issues in the clients' lives that she had little control over changing; fortunately, she learned to trust that her relationship with her clients could be therapeutic nonetheless.

Some of Gina's learning also occurred in relation to school staff who evidently suffered from vicarious trauma. Teachers were under a lot of pressure to manage large classrooms, often with numerous disruptive students, and it could be difficult for them to understand the distress motivating the students' behaviors. Gina learned to help teachers empathize with students, discussing symptoms of complex trauma with them. She was gratified as she could help teachers better understand children's behavior and not be so quick to send the students to get a suspension. Other teachers were loathe to have children taken out of class, especially when it got close to standardized testing time. Gina worked with the teachers about the importance of social work services for the students that were suffering from trauma and explained that her services could improve students' concentration. Other teachers needed someone to listen to them and validate their frustrations. While Gina could not resolve many of the challenges the teachers were experiencing, she learned she could effectively support them.

Conclusion

The Empowering Counseling Program developed an educational and service program for profoundly disadvantaged, urban African-American children and youth that can be readily implemented by any school of social work in partnership with community schools. Children and youth suffering from complex trauma need services that are long-term, flexible, and comprehensive (in the sense of welcoming the client's entire ecosystem in care). The very survival of clients is frequently in question, and social workers often are the only stable persons in their lives who can offer comfort and affirm their strengths. Practitioner focus is overwhelmingly on offering a relationship that the client experiences as caring and compassionate, so the client can become attached in the

ways s/he needs to in order to advance her/his development. Clearly, "social exclusion" and attrition can be overcome: When youth feel respected and cared for, they show up (99% participation for individual counseling and 86%-99% for group leadership program), and they enthusiastically become active in seeking to resolve community problems and in caring for other community members. Finally, children and youth can change for the better even if their parents cannot engage in counseling. Most of all, we have learned that although the obstacles to providing empowering mental health care for clients in profound poverty is challenging, through partnership it can be done.

[1] For those who are interested, we have more information available in the form of articles, dissertations, and presentations – feel free to contact Prof. McCrea (ktyson@luc.edu) if you would like more information.

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