THE PERSPECTIVE OF CLINICAL CASEWORKERS ON THE DEVELOPMENTAL TRAUMA EXPERIENCES OF YOUTH LIVING IN GROUP HOMES AT RANCH EHRLO

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ABSTRACT

Trauma is a common problem experienced by marginalized children, youth, and their families. It affects physical health, mental health, and relationships and often manifests as problematic behavior for which youth within the child welfare system in Canada are institutionalized. This research utilizes a critical realist perspective of disability, a developmental trauma disorder (DTD) approach, and ethnographic methods with the aim to understand the perspectives of caseworkers working with youth who have experienced trauma and are now residing in Ranch Ehrlo Society’s (RES) group homes. The data collection consisted of six semi-structured interviews with clinical caseworkers who work in RES’s residential programs. According to the data, the youth present trauma exposure and symptoms and behaviors as described by DTD diagnostic criteria. Other findings that emerged include the community, familial, and child welfare factors that contribute to the trauma; considerations for trauma-informed care; and resilience. In conclusion, a DTD approach and a critical realist perspective contribute to inform the problem in an innovative and coherent manner, offering social workers knowledge in advocating for social justice, developing professional competency, and enhancing interdisciplinary work.

Key words: social work, developmental trauma, youth, children, residential treatment, critical realist perspective of disability, Ranch Ehrlo Society.
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LIST OF ABBREVIATIONS

ACES: Adverse Childhood Experiences studies
ADHD: Attention-Deficit/Hyperactivity Disorder
DSM: Diagnostic and Statistical Manual of Mental Disorders
DTD: Developmental Trauma Disorder
NCCTS: National Center for Child Traumatic Stress
ODD: Oppositional Defiant Disorder
PTG: Post-Traumatic Growth
PTSD: Post-Traumatic Stress Disorder
RES: Ranch Ehrlo Society
CHAPTER ONE: INTRODUCTION

This research practicum report presents research conducted during the fall semester of 2015 and the winter semester of 2016 as part of the Master of Social Work program at the University of Regina, Canada. During my social work practice in Chile and Canada, I have worked with children, youth, and their families. I have witnessed poverty and marginalization faced by families. I believe that social conditions often cause and exacerbate the experience of trauma. My research focused on caseworkers’ experiences of working with youth at Ranch Ehrlo Society (RES) in Regina who had experienced trauma. In this research report, the reference to children and youth is used interchangeably and means those between 12 and 18. Many of these youth require intensive care and treatment for a variety of social and emotional difficulties, as well as challenges related to trauma.

Trauma is a complex issue, and youth in residential treatment settings are among the most affected by it with multiple trauma exposure (Briggs et al., 2012 as cited in Pond & Spinazzola, 2013) and physical, emotional, and behavioral difficulties. Using the developmental trauma disorder (DTD) perspective, a critical realist perspective of disability, and ethnographic methods, this study aims to understand the perspectives of caseworkers who work with youth experiencing complex trauma who reside in RES’s group homes.

The research question guiding the study is: What is the perspective of the clinical caseworkers on the developmental trauma experiences of youth residing in RES’s group homes? The sub-question is: How do the caseworkers view and work with youth at Ranch Ehrlo who have experienced trauma?
**Organization of Chapters**

This report is organized into seven chapters beginning with the introduction. Chapter Two explains how a critical realist perspective of disability applies to this research. Chapter Three covers a review of literature on trauma of children and youth in residential care settings. Chapter Four describes the qualitative methodology of ethnography I used. The description of the findings forms Chapter Five. Chapter Six focuses on the analysis of the study findings. Finally, Chapter Seven presents theoretical and practical implications of the study as related to the profession of social work.
CHAPTER TWO: THEORETICAL PERSPECTIVE

This research utilizes the critical realist perspective of disability in order to incorporate a more holistic view of illness. Trauma has been traditionally understood from a medical perspective, focusing on the problems within the individual (Withers, 2012) and the use of medicine as a way to control or “fix” the problem, without considering social factors that contribute to the trauma.

Developmental trauma disorder is a new way of understanding experiences of traumatic conditions among children. It will be discussed in more detail in Chapter Three, but for now, I will focus on the critical realist perspective of disability that combines both medical and social models of disability to examine how people are disabled by their impairments and by society (Shakespeare, 2014). The medical model of disability focuses on the treatment of the individual’s impairments while the social model is concerned with the societal exclusion experienced by persons with disabilities, including traumatized children and youth.

The current proposed diagnostic criteria for developmental trauma disorder considers medical views (e.g., that trauma affects the body, such as brain changes; that trauma results in impairments, such as emotional and physical dysregulation) and social aspects (e.g., systemic considerations such as youth experiencing multiple placements within the child welfare system and difficulties in areas of education and peer group) of disability. Youth that meet the DTD diagnosis are disabled by both their impairments and society; they experience the effects of trauma in their bodies and in their relationships and are excluded by society when placed in residential, correctional, or psychiatric settings.
A critical realist perspective links well with developmental trauma disorder and also the concepts of embodiment, resilience and strengths perspective in order to explain the trauma experienced by youth at RES. In addition, critical theory is considered appropriate when addressing issues of developmental trauma from a social work perspective (Payne, 2005).

The concept of embodiment as understood by Nancy Krieger (2005) complements the idea of the social model of disability. The idea of embodiment emerges from the field of social epidemiology and explains the social origins of illness, in other words, how health and physical consequences derive from social inequalities. According to Krieger (2005), exposure to interpersonal trauma is a pathway to embodying discrimination.

The concept of resilience is utilized in this research in order to explain the positive consequences of exposure to trauma. The views on resilience (Ungar, 2013) and healing from a strengths perspective (Saleebey, 2013) utilized in this study support the combination of individual and social factors as understood from a critical realist perspective. As Saleebey (2013) states, healing requires the “facility of the body and the mind to regenerate and resist when faced with disorder, and bodily or psychological disruption . . . [and a] beneficent relationship between the individual and the larger social and physical environment” (p. 15).

In summary, the theoretical perspective I used for this research includes a critical realist perspective of disability and social and medical aspects of trauma, which embodiment explains by evidencing the social causes of trauma and the derived impairments that the youth experience. Looking at resilience and strengths compliments
the views on trauma and exposes the positive consequences of trauma, as well as opening up avenues for recovery.
CHAPTER THREE: LITERATURE REVIEW

This literature review offers some background information on trauma-related research that helps us to understand how trauma is conceptualized; the evolution of trauma diagnosis among children; and the emerging developmental trauma disorder, which pertinently applies to youth, a population that is the focus of this paper. The effects of trauma on children and youth (from birth to age 18) is explained at different levels (biological, physical, social) and some contextual information is provided for youth in care. The literature review is based on information written in the last 10 years from academic journals (mainly retrieved from the Social Services Abstracts database) and relevant books.

Psychologist Pierre Janet first began to study trauma in 1889 in order to understand the experiences and difficulties of war veterans in what he called traumatic stress (as cited in van der Kolk, 2014). In 1980, Post-Traumatic Stress Disorder (PTSD) was incorporated as a new diagnosis by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders (DSM) III. It described symptoms that were common for war veterans who would otherwise be diagnosed with “alcoholism, substance abuse, depression, mood disorder, even schizophrenia” (van der Kolk, 2014, p. 13). Another important work in relation to trauma is by the feminist author Judith Herman, who in 1992 published Trauma and Recovery, in which she argued that psychological trauma was part of a broader social context. As van der Kolk (2014) points out, Herman’s work was part of the feminist movement, which when combined with an awareness of trauma, motivated survivors of trauma to speak about their experiences.
What is Trauma?

There are direct and indirect impacts of trauma on an individual. Direct impacts of trauma can result from “events involving threat or danger” (Berliner, 2013, p. 4), which may not necessarily be violent. Indirect trauma can be experienced by witnessing violent events as they occur or happen to a loved one (Berliner, 2013). Examples of traumatic experiences are physical or psychological abuse or neglect, sexual abuse, crime, domestic violence, community violence, accidents, natural disasters, serious illness or injury, violent or sudden death of a loved one, loss or separation of a caregiver, and war (Berliner, 2013).

As Lanktree et al. (2012) note, for children and youth, trauma can often involve a combination of adverse experiences, and when this exposure to trauma happens early in life, it can lead to insecure attachment for a person. The trauma experienced by children can also be exacerbated by environmental or socioeconomic conditions, stigmatization, and experiences of marginalization and discrimination. For example, experiences of oppression can be traumatizing and poverty can worsen the trauma (Brokenleg, 2012). Oppression may have internal or external impacts on an individual, but internalized oppression is the most detrimental (Brokenleg, 2012) because of the negative psychological effects, which can lead to self-hatred and low self-esteem.

I will now discuss a more detailed understanding of how trauma affects youth and how DTD and resilience can inform the experiences and consequences of trauma.

The Evolution of Diagnosis among Children

There have been varying perspectives within the study of children and youth who experience trauma. Currently, PTSD is the diagnosis that explains trauma in the
psychiatric field. Based on the American Psychiatric Association DSM-V (2013), PTSD is defined as the “exposure to actual or threatened death, serious injury or sexual violence” (PTSD section, para. 1) to self or others. It includes the following elements:

- intrusive symptoms such as recurring, involuntary and intrusive memories, distressing dreams, dissociative reactions, which may include flashbacks, intense or prolonged psychological distress and marked physiological reactions to internal or external cues related to the traumatic event (American Psychiatric Association DSM-V, 2013).

- a persistent avoidance of traumatic cues, negative alterations in cognition and mood, and increased arousal (irritability, hyper-vigilance, problems with concentration and sleep) (American Psychiatric Association DSM-V, 2013).

Available research notes the lack of an integrative diagnosis that informs the complex trauma that many children and youth experience, as PTSD does not capture the developmental consequences of interpersonal trauma for children (Ai, Jackson Foster, Pecora, Delaney, & Rodriguez, 2013; Cook et al., 2005; d’Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Ford et al., 2013; Sar, 2001; Spinazzola et al., 2005; van der Kolk, 2015/2014; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Developmental consequences of trauma exposure refer to the effects in brain maturation, cognitive development, and emotion-behavior regulation that can lead to a chronic inability through adolescence and into adulthood to modulate emotions (Ai et al., 2012). These developmental impairments place the youth at risk for impulsive behaviors, difficulties with interpersonal relationships, additional trauma exposure, and cumulative impairments (Ai et al., 2012; Cook et al., 2005)
In 2001, the National Child Traumatic Stress Network (NCTSN) was created in the United States, and it became the first organization dedicated to the comprehensive research and treatment of traumatized children (van der Kolk, 2014). Spinazzola et al. (2005 as cited in van der Kolk, 2015/2014) found that “eighty-two percent of the children seen [in this network] do not meet the diagnostic criteria for PTSD” (p. 157). Traumatized youth often present comorbid symptoms related to trauma and a diagnosis of PTSD (Ai et al., 2012; Ford et al., 2013). Cook et al. (2005) described the symptoms that often accompany a diagnosis of PTSD for children exposed to interpersonal trauma: “depression, attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder, anxiety disorders, eating disorders, anxiety disorders, sleep disorders, communication disorders, separation anxiety disorder, and reactive attachment disorder.” (p. 392). Comorbidity seems to be the rule for clinical presentation among children, and the complexity of symptoms increases with added traumatic stressors (d’Andrea et al., 2005).

The problem with not having an appropriate diagnosis is that many of the needs of traumatized children are overlooked (d’Andrea et al., 2005), or children are treated for a multiplicity of diagnoses without effectiveness, as they often “do not respond well to disorder-specific treatment” (p. 194). An integrative diagnosis that considers multiple causes, as well as symptoms and behaviors could have several benefits as discussed in the following section on developmental trauma disorder.

**Emerging Perspectives on Trauma among Children**

The literature I consulted for this study identifies a variety of concepts utilized in relation to trauma experienced by children. The most common include complex trauma
(Cook et al., 2005; Spinazzola et al., 2005), interpersonal trauma (d’Andrea et al., 2012; van der Kolk, 2005), post-traumatic stress (Berliner, 2013), developmental trauma (Courtois, 2004 as cited in Sar, 2011), cumulative trauma (Cloitre et al., 2009 as cited in Sar, 2011), and toxic stress (Garner et al., 2012). These emerging perspectives point to the need to explain the complexity of the issue of trauma affecting children and youth.

**Developmental trauma disorder (DTD)**

For my research, I chose to focus on DTD, an emerging psychiatric concept that aims to reflect the experiences and effects of interpersonal trauma in childhood. It may provide a more accurate and relevant diagnosis for children who suffer from trauma, those presenting symptoms of PTSD, and those that have a number of unrelated diagnoses or no diagnosis. DTD includes PTSD symptoms within its diagnostic criteria, while adding interpersonal factors to the trauma exposure, such as changes in the caregiving system. It also takes into consideration areas of impairment in the familial, peer group, educational, legal, health, and vocational domains (see Appendix A). The conceptualization of trauma from this perspective emerges from the work initiated by the Trauma Center located in Brookline, Massachusetts. In 2005, the NCTSN proposed the DTD (van der Kolk, 2005) as a response to the limitations of the psychiatric diagnosis previously explained. DTD as a diagnosis was considered, but it was not incorporated into the DSM-V.

The benefits of incorporating DTD as a psychiatric diagnosis and using it in direct practice are reduction of diagnostic confusion (d’Andrea et al., p. 194); avoidance of pathologizing and multiple labeling/diagnoses (d’Andrea et al., 2012; Stolbach et al., 2013); replacement of multiple treatments associated with comorbidity with
psychobiological dysregulation-focused treatment (Ford et al., 2013); and a focus on the treatment of trauma (Ford et al., 2013; Levin, 2009) rather than the use of polypharmacological approaches (that come from diagnoses like ADHD and BD/PBD).

Other advantages of identifying DTD as a diagnosis have been shown in the literature. They involve using a cohesive approach that allows for scientific progress and also benefits patients who are currently served by a medical system that has a fragmented response to the effects of stress (Sar, 2011), such as multiple diagnoses and the use of medications. List (2013) also argues that if DTD is recognized by the mental health field as a diagnosis then treatment and funding can focus more on prevention and early intervention. However, the remaining problem is that research on developmental trauma needs to be further explored to better serve the needs of children and youth.

**Consequences of Trauma Exposure**

The consequences of traumatic experiences are widely reported in the literature. Although no direct causality is drawn from a single reported event, the symptoms and negative effects result from a combination of complex exposure to violence, abuse, and neglect (Collin-Vezina et al., 2011; Cook et al., 2005; d’Andrea et al., 2012; Haliburn, 2014; Lanktree et al., 2012; Wood, 2003 as cited in Collins et al., 2011; Spinazzola et al., 2005; van der Kolk, 2005, 2014).

Many children exposed to trauma may experience significant adverse effects including cognitive, physical, psychological, affective, interpersonal and behavioral (Racco & Vis, 2014). These effects can extend into adulthood (Racco & Vis, 2014). The following sections explain the different types of consequences of trauma as reported by
Dissociation and hyper-arousal

According to Perry and Szalavitz (2006), dissociation and hyper-arousal are two common responses to trauma that can help individuals survive the trauma. However, if they persist, they can become part of post-traumatic stress. This may explain how “maltreated children are either hypersensitive or avoidant in response to negative emotional stimuli” (d’Andrea et al., 2012, p. 189). Dissociation and hyper-arousal responses can be misinterpreted by diagnoses of attention and conduct problems (Perry & Szalavitz, 2006).

“Dissociation is one of the consequences of developmental trauma” (Sar, 2011, p. 3) and is defined by van der Kolk (2014) as the “essence of trauma” (p. 48). Although it is beyond the scope of my research, dissociation is considered a crucial feature of complex trauma, which is described as a protective state in which the person experiences traumatic reminders consisting of a psychological and physical disconnect and awareness (Cook et al., 2005 as cited in Racco & Vis, 2014, pp. 122–123). Dissociation is a disorder on its own, and it may be present in other psychiatric disorders such as PTSD (Sar, 2011).

Hyper-arousal is a fight or flight response to fear that “allows faster reactions in short periods of time and helps immediate survival” (Perry & Szalavitz, 2006, p. 49). But when fear becomes sustained, hyper-arousal constitutes a constant maladaptive state (Perry & Szalavitz, 2006). Aggression and impulsivity that this state presents can often be interpreted as defiance or opposition (Perry & Szalavitz, 2006).
The freeze and fight or flight responses to trauma as described by dissociation and hyper-arousal is only part of how an individual responds to trauma. The next section describes in more detail how trauma evidences in the brain when stress becomes chronic.

**Neurobiological effects of trauma**

There are a number of documented effects of child maltreatment on the structure and function of the brain and endocrine system. Structural alterations of the brain as a result of trauma include volume reduction in the corpus callosum (de Bellis et al., 2012; Teicher et al., 2003), prefrontal cortex and temporal lobe (de Bellis et al., 2012), and left neocortex, hippocampus, and amygdala (Teicher et al., 2003).

Functional alterations of the brain include decreased amygdala activation (Taylor, Eisenberger, Saxbe, Lehman, & Lieberman, 2006), alterations in diurnal cortisol variation (Bevans, Cerbone, & Overstreet, 2008), and blunted cortisol reactivity related to lower social competency (Hart et al., 1995 as cited in d’Andrea et al., 2012). When a traumatized person re-experiences the trauma, an elevation of emotional reaction occurs, along with a suppression of emotion regulation and communication (Racco & Vis, 2014). Therefore, multiple functioning domains of the brain are affected simultaneously (Racco & Vis, 2014).

The effects of trauma on the brain vary depending on the timing and duration of maltreatment, gender, and time of assessment (Watts-English, Fortson, Gibler, Hooper, & DeBellis, 2006 as cited in Ai et al., 2013, p. 3). The stress resulting from maltreatment is linked to prolonged and elevated stress hormones that cause dysregulation of the neurobiological systems involved in brain maturation, cognitive development, and emotion/behavior regulation (Cohen, Perel, DeBellis, Friedman, & Putnam, 2002). The
dysregulation in neurobiological systems is reflected in biopsychosocial consequences of trauma as described in the following section.

**Biopsychosocial consequences**

Exposure to interpersonal trauma can have effects on the social, psychological, cognitive, and biological aspects of development (Cook et al., 2005; Spinazzola et al., 2005). D’Andrea et al. (2012, pp. 189–190) documented, from a variety of studies, the relationship of interpersonal trauma during childhood that resulted in a variety of symptoms:

- increased incidence of affect dysregulation (e.g., lability, anhedonia, flat or numbed affect),
- behavior dysregulation (e.g., withdrawal, self-injury, aggression, oppositional behavior, substance use, or other compulsive behavior),
- alterations in attention and consciousness (e.g., dissociation, depersonalization, memory disturbance, inability to concentrate);
- disrupted executive functioning (e.g., lack of ability to plan, problem solve),
- disturbances of attribution and schema (e.g., globalized shame and guilt, a negative cognitive style, distorted locus of control, poor self-efficacy), and
- interpersonal difficulties (e.g., disrupted attachment styles, difficulties with trust, low interpersonal effectiveness, diminished social skills, inability to understand social interactions, poor perspective-taking abilities, expectations of harm from others, and poor boundaries).
Based on this detailed description of behavioral symptoms that evidence trauma consequences, which are also reflected in DTD diagnostic criteria, the following section discusses physical consequences of exposure to trauma.

**Adverse Childhood Experiences studies (ACEs)**

ACES have documented long-term physical and psychological health effects from childhood trauma, including increased risk of adult tobacco, alcohol and drug use, overeating, high-risk sexual behavior (Baglole & Workman, 2011), and an increase in the risk of “ischemic heart disease . . . liver disease . . . chronic obstructive pulmonary disease, lung cancer and sexually transmitted infections” (Baglole & Workman, p. 1804). ACE studies use a rating system that covers the areas of physical, sexual, or emotional abuse, severe neglect, and household dysfunction (Baglole & Workman). In terms of health status, the following have been noted with increased rate of ACES: “more teen pregnancy and fetal death, more depression and hallucinations, more suicidal thoughts and behaviours, and more prescription drug use” (Baglole & Workman, p. 1804).

Figure 1 shows the pyramid created by ACES to explain the health effects of adverse childhood experiences and how they relate to disrupted neurodevelopment, impairments, and adoption of high-risk behaviours, which subsequently lead to disease, social problems, disability, and even early death.
The study of trauma in children and youth present a variety of challenges. Trauma is a very broad subject, and “the mental health community has struggled to comprehensively and systematically describe the effects of childhood victimization” (d’Andrea et al., p. 188). As Ai et al. (2013) explain, causality should be carefully considered in regards to the current association between child maltreatment and psychiatric disorders. The authors further claim that the relationship between child maltreatment and psychiatric disorders can be made worse by other developmental (i.e. learning disorders) and social risk factors such as poverty and limited social support network. However, what is less talked about are the positive consequences related to trauma, which are discussed in the following section.

Positive consequences and resilience

Ai et al. (2013) explain that there are also positive consequences of individuals responding to trauma, known as post-traumatic growth (PTG). This response can be normative and coexist with PTSD symptoms. Adversity-based gains from PTG include
meaningful interpersonal relationships, new ways of viewing oneself, and changed worldviews (increased spirituality, realization of new opportunities, and a greater appreciation for life).

Resilience is another important concept to consider when looking at positive adaptations to trauma. This study utilizes Ungar’s (2013) definition of resilience as “the capacity of both individuals and their environments to interact in ways that optimize developmental processes” (p. 256). The person experiencing adversity would present behaviors that help find the resources to flourish (Ungar, 2013, p. 256). Therefore, resilience is a process developed from a combination of personal and environmental factors that contribute to development (Blaustein & Kinninfrared, 2010; Ungar, 2013). Resilience not only refers to individual factors, but also to the capacity of the environment to provide resources needed for positive development (Ungar, 2013). Examples of a supportive environment are “making education accessible; promoting a sense of belonging in one’s community; facilitating attachment to a caregiver” (Ungar, 2013, p. 255). Attachment plays a crucial role in the development of socio-emotional skills, as the main caregiver becomes the base for the development of a healthy attachment.

Detrimental consequences of developmental trauma and resilience can co-exist (d’Andrea et al., 2012; Ungar, 2013), as resilience comes from exposure to stress (Blaustein & Kinninfrared, 2010). This explains how traumatized children can present mental health problems as well as thrive and adapt to their environment despite difficulties. Individuals can present strengths in some areas and not in others (Ungar,
According to Ungar (2013), resilience can present either as pro-social behaviors or pathological adaptations, depending on the environment.

The conditions that foster resilience are called protective factors. The presence of a secure caregiver-child attachment is considered the main defense against developing psychopathology from trauma (Levy & Orlans, 1998). “Attachment provides a secure base which leads to healthy social development” (Levy & Orlans, 1998, p. 2), including the development of self-regulation, identity, pro-social skills (empathy, compassion, conscience), a core belief system, and defense against stress and trauma (Levy & Orlans, 1998).

Working towards enhancing resilience means building on strengths (d’Andrea et al., 2012), looking at the social/context conditions, and empowering youth to share their own perspectives of resilience (Ungar, 2013). The primary treatment goal in working with children exposed to traumatic stress is to build on those factors that contribute to healthy development (Blaustein & Kinninburgh, 2010). Ungar (2013) also notes that “the positive outcomes of maladaptive coping strategies are necessary when risk exposure continues to be high and change to socially acceptable behavior actually puts the individual at risk” (p. 263).

I will now turn to a discussion of the relevant literature on trauma experienced by children in residential settings, as this is the focus of my research.

**Trauma of Children and Youth in Care/Residential Settings**

My research focuses specifically on reporting and understanding the experiences of trauma by children and youth in the context of a residential care setting. Children and youth in out-of-home placements, being among the most vulnerable youth, are especially
at risk of experiencing interpersonal trauma (Collin-Vézina et al., 2011). Child maltreatment is the main reason that children are placed out of the home (Ai et al., 2013). Physical abuse, neglect, sexual abuse, and family violence are examples of child maltreatment (Connor et al., 2004 as cited in Collin-Vézina, 2011; Cook et al., 2005) that expose many children in the child welfare system to trauma (Berliner, 2013).

Youth in care present a variety of problems more frequently than do those from the general population. These problems appear in the areas of physical and mental health, social, developmental, and educational (Collin-Vézina et al., 2011). According to Cook and Tedeschi (2007 as cited in Ai et al., 2013) most youths in foster care have experienced trauma within their family, including the trauma of being removed from their families. The authors argue that these youths present a higher risk of developing behavioral and psychiatric symptoms, with higher rates of PTSD and post-traumatic stress symptoms (PTSS) than in the general population.

A national study in the United States showed that for children and youth referred to social welfare services, those in out-of-home placements (e.g., kinship care, foster care or residential/congregate care) experienced higher rates of trauma symptoms than those who stayed at home during service provision (Kolko et al., 2010 as cited in Collin-Vézina et al., 2011). Collin-Vézina et al. (2011) studied a sample of 53 Canadian youth, aged 14 to 17, in residential care in order to understand trauma experiences, consequences, and resilience features among this population. Based on the study by Collin-Vézina and her colleagues, 68 per cent of the children had experienced emotional abuse, 60 per cent of them had suffered physical abuse, emotional neglect accounted for 58 per cent, and physical neglect for 98 per cent. Additionally, 38 per cent of the youth
reported sexual abuse. More than half of the sample reported experiencing four to five different forms of abuse or neglect. There were no gender differences associated with experiencing multiple forms of maltreatment, except for sexual abuse. A high proportion of the females reported a history of sexual abuse (63%) in comparison to the males (17%). These findings demonstrate how children and youth in residential care are particularly vulnerable to trauma exposure and trauma-related effects, with high levels of multiple trauma experiences.

Psychiatrist Levin (2009) explains that in addition to trauma exposure, children and youth in residential care are often misdiagnosed and tend to be treated with high doses of multiple medications. These pharmacological interventions focus on controlling the behaviors rather than working with the trauma exposure.

In relation to the background of youth in residential programs, youth in care tend to enter the programs from settings that are not their original family home, and their families present significant risk behaviors such as substance abuse, criminal involvement, and presentation of psychiatric problems (Griffith et al., 2009 as cited in Zelechoski et al., 2013). When caregivers/familial members experience trauma from maltreatment or domestic violence, children and youth can present disruptions in their development (d’Andrea et al., 2012). Levy and Orlands (1998) point out that the majority of high-risk families, those who suffer from “poverty, substance abuse, abuse and neglect, domestic violence, history of maltreatment in parent’s childhood, depression, and other psychological disorders in parents” (p. 1), foster disorganized patterns of attachment with their children. Additionally, when parents have experienced trauma, it becomes more difficult for them to provide their children with support and safety if their
own trauma remains unaddressed (Tullberg, 2013). Factors such as having parents with trauma histories, living in high-risk communities, being placed in an institution, and having an indigenous background, make it more likely for youth to experience trauma. Traumatic experiences are common among children who live in or come from high-risk communities. They can be exposed to extreme violence such as assaults with weapons or witnessing homicides (Brokenleg, 2012). Other conditions such as “poverty, diminished social resources, racial discrimination, and chaotic living conditions” (Lanktree et al., 2012) are also factors that lead many youth in urban settings to experience trauma (Brokenleg, 2012). As Collins et al. (2011) explain, such factors would lead to parents and children developing and increasing trauma symptoms, difficulties in parenting, and a higher risk for child maltreatment.

Institutions, Trauma-Informed Systems

Traumatized children and youth in care can be further affected and disabled by societal institutions. Focusing on trauma-informed practices and systems could help with a paradigm shift towards supporting youth who are involved with the child welfare system.

A trauma-informed child welfare system recognizes the impact of trauma on children, their caregivers, and other people involved, and it supports resilience and recovery within programs and practices (Chadwick, 2011 as cited in Wilson, 2013). As Cooper and Aratani (2013) state, a trauma-informed framework focuses on preventing trauma, works with trauma effects, and avoids causing further harm. RES adopted the “sanctuary model,” which is designed as “an ‘operating system’ to create trauma-informed communities in group care programs” (Kagan & Spinazzola, 2013, p. 707),
The “operating system” includes organizational principles and can include more than one treatment model. Benefits of utilizing this model include the reduction of behavioral difficulties in the youth while in residential treatment (Rivard et al., 2003 as cited in Kagan & Spinazzola, 2013).

Some institutional changes that would contribute to working towards trauma-informed systems are noted in the literature. These include educating staff on developmental and psychosocial matters, trauma, and attachment theory (Levin, 2009); becoming less focused on outside control and focusing, instead, on self-control (Levin, 2009); focusing on permanency as a goal; minimizing placement disruption; and working on family preservation (Pond & Spinazzola, 2013).

The literature shows a gap in empirical research regarding the trauma experiences of youth in residential settings, likely because collecting data on this population group is challenging (Collin-Vézina et al., 2011). Some of these challenges include the inaccessibility of caregivers from families of origin, limited background information provided by the referring agency, and lack of trauma-screening tools in residential settings (Collin-Vézina et al., 2011).

The study of outcomes of trauma treatment is challenging as well, partly due to the multiplicity of symptoms, and also because the duration of treatment varies depending on the particular needs of each person. Relational difficulties (which are often related to childhood trauma) are overlooked by short-term interventions, and socially marginalized children and youth are underrepresented in the treatment studies (Lanktree et al., 2012).
The study of trauma experienced by youth in residential settings is also understudied, and most research on children in care focuses on describing behavior and emotional difficulties without linking these problems to trauma-specific research or measures (Collin-Vézina et al., 2011). Zelechosky et al. (2013) point out that research in relation to youth in residential settings is substantial as is research on youth who experience complex trauma; however, there is not a lot of research that brings these two together, nor on the treatment considerations that would be suitable.

In terms of the research context, much of the research on youth experiencing trauma emanates from the United States; therefore, further developing research in Canada would provide the particular social context that is necessary for understanding this area, especially when evaluating treatment options for children (Collin-Vézina et al., 2011).
CHAPTER FOUR: METHODOLOGY

This chapter presents the methodological components of the study, including the ethnographic research approach, a description of the research setting, data collection methods, ethical considerations, and data analysis.

My research was based on a qualitative methodology because it aims to understand the perspectives of the caseworkers who provide services to children who experience trauma. Qualitative research elements that are present in this study include exploring the participants’ meanings, the use of a theoretical lens, and inductive data analysis (Creswell, 2007).

This research is ethnographic, which Whitehead (2005) describes as a holistic approach in which “socio-cultural contexts, processes, and meanings within cultural systems” (p. 4) are studied in a flexible process. The use of ethnography in this research is evidenced from my interest in learning about trauma as experienced by children and about caseworkers themselves and their perspectives on working with children who have experienced trauma.

Reflexivity

Reflection plays an important role in ethnographic research as a way for me, the researcher, to maintain awareness of my own thoughts, feelings, and emotions during fieldwork (Andrews, 2005), as well as to “establish that the researcher is linked to the phenomena” (Hammersley & Atkinson, 1983 as cited in Andrews, 2005, p. 208). Reflexivity can evince how the “researcher’s views, background, and interest may influence the research” (Krefting, 1991 as cited in Gulati, 2011, p. 550).
I recognize the importance of reflexivity in research because of my own experiences. Growing up in an environment of marginalization and political oppression, as well as experiencing other traumatic events, I recognize how these experiences have shaped my interest in social work and working with children and their families who have traumatic experiences. In my social work practice, I have observed issues common to both Canada and Chile of how social conditions contribute to experiences of trauma. Given my past experiences, I am aware of the ways in which traumatized youth express and cope with their emotional pain, as well as the importance of relationships in fostering resilience. Formerly, I worked at RES as a therapist in the Family Treatment Program; therefore, my interest in this particular research setting has been influenced by this work experience. Additionally, I had access to knowledge of the organizational culture and some understanding of the trauma experienced by youth. I had also met some of the research participants previous to the research implementation.

The Setting

The research was conducted at RES, which was founded in 1966 by Dr. Geoff Pawson. The mission of the agency is “to provide quality prevention, restorative, and advocacy services to vulnerable individuals and families” (Ranch Ehrlo Society, 2014). RES has a variety of programs, including the Residential Program with group homes in Regina/Pilot Butte, Corman Park, and Prince Albert. There are approximately 175 residential treatment placements as well as residential treatment options for those with differing developmental disabilities (S. Grahame, personal communication, September 2015). Many of the youth who participate in programming have experienced trauma and have diagnoses including Attention Deficit Hyperactivity Disorder (ADHD),
Oppositional Defiant Disorder (ODD), Conduct Disorder, Reactive Attachment Disorder, Depression, and Separation Anxiety (Rivers & McEwan, 2009). In 2006, RES began exploring the implementation of trauma-informed care in order to reduce the use of unnecessary physical restraints (Ranch Ehrlo Society, n.d.).

RES was selected as the research setting due to its rich history and the expertise of its staff in working with traumatized youth. The children/youth living in group homes are very likely to fit the DTD diagnostic criteria. In addition, many of the clinical caseworkers working at the group homes are social workers, which can help in understanding trauma-informed work from the professional perspective.

Data Collection

Data collection involved semi-structured interviews, a review of trauma-related documents from RES, and secondary data collection in the form of the literature review of this report. Before, during, and after the interviews took place, I collected material related to the agency to help lay the foundation for and provide the context of the research. This information included the history of RES, its mission, and the implementation of trauma-informed care within the organization.

Participant recruitment

The ethics approval for this research was a two-step process. First, ethics approval for this study was obtained from the University of Regina Research Ethics Board on September 2015, prior to participant recruitment. Second, I also sought approval of this research from the RES Ethics Review Committee. The process of obtaining ethics approval at Ranch Ehrlo was largely facilitated by a professional associate, or the key informant, who played two significant roles in helping to launch the
research study. Initially, the key informant helped with obtaining ethics approval from RES’s Ethics Review Committee by submitting a research proposal to the CEO of Ranch Ehrlo. The key informant also facilitated participant recruitment by providing information regarding the research project to potential participants, as well as providing me with relevant information in relation to trauma-informed care within the agency (see Appendices B and C).

Initially, the key informant discussed the research idea with possible interview participants, provided them with the research information letter (see Appendix D) and the participant consent form (see Appendix E so that the caseworkers would have background information before agreeing to participate in the study.

Recruitment was based on availability and willingness to participate in the study. The participants who volunteered to take part in the research contacted me via email. The interviews were then arranged via email. All of the interviews, except one, took place in the caseworkers’ offices at a group home during working hours. As I am a former employee of the agency, the pre-existing work relationships were an advantage to the participant recruitment as the research participants were interested in volunteering for the interviews. This was also an advantage for the establishment of rapport during the interviews.

I conducted semi-structured interviews in December of 2015 (see Appendix F) with six clinical caseworkers who work with youth in RES’s group homes. The duration of each interview was approximately an hour, and these interviews were audio recorded and later transcribed verbatim.
Ethical Considerations

It is my hope that the research results will contribute to an understanding of trauma experiences and the needs of youth who are residents at RES and provide a perspective that evidences medical as well as social considerations.

Although my intention was to understand the trauma of the youth, I interviewed caseworkers rather than the youth in order to protect the identity of the youth who are part of a vulnerable group and to avoid re-traumatizing them by having them talk about their experiences of trauma. The caseworkers’ perspectives and their integration of knowledge regarding trauma enhances their ability to practice effectively with the youth whom they provide service to.

Being a researcher and having pre-existing relationships with some of the research participants presented an ethical dilemma. I discussed this concern with the members of my research practicum committee, and we decided that it would be important for me to acknowledge these relationships when I wrote up the study results, as well as to note that the previous nature of these relationships allowed for trust and gaining access to rich data.

As previously stated, the participants had access to the consent form before agreeing to participate in the study. They signed the consent form before the interview took place, and I informed them of their right to withdraw from participating in the study.

Confidentiality

This study presents limits to confidentiality due to selection, as the participants could be identified from the small number of caseworkers available in relation to the
number selected for interviews. There are thirteen caseworkers at the Regina and Pilot Butte locations who meet the selection criteria, and I interviewed six of them.

To guard against breach of confidentiality, I included member checking so that any identifying information could be removed from the research findings, and pseudonyms are used when quoting the participants in this report. In order to protect the anonymity and confidentiality of the youth whom the caseworkers discussed during the interviews, any information that might identify the youth is not be included in the research report or research dissemination activities.

Data Analysis

The analysis follows the thematic guidelines described by Braun and Clarke (2006), which is a widely used method in qualitative analysis. It is a flexible methodology in that it can be used for different theoretical frameworks. It also fits with a critical realist theory as it “acknowledge[s] the ways individuals make meaning of their experiences, and, in turn, the ways the broader social context impinges on those meanings, while retaining focus on the material and other limits of ‘reality’” (Braun & Clarke, 2006, p. 81). My analysis of the research findings is also theoretical and semantic. It is theoretical in that it focuses more on providing a “detailed analysis of some aspect of the data” (Braun & Clarke, 2006, p. 84) that relates the coding to a specific research question and semantic in that it identifies the themes within the explicit meaning of the data.

The steps I took in the thematic analysis of the data, as described in Braun and Clarke, (2006), include: (a) familiarizing myself with the data by conducting the interviews and transcribing the audio files; (b) generating initial codes; (c) searching for
themes; (d) reviewing the themes and creating a thematic map; (e) defining and naming themes and analyzing the data within them; and (f) producing the written analysis for the report, utilizing quotations to substantiate the themes.

The interviews were audio-recorded and transcribed as computer files. They were then codified with NVivo 10.2.2, a qualitative data analysis software. Coding the transcripts was carried out by matching portions of the transcripts with categories of investigation corresponding to themes that emerged from the literature review. The research process, focused on the perspectives of the caseworkers, allowed for new themes and ideas to emerge which were not previously considered by the review of literature.

**Strengths and limitations of the study**

The strength of this research lies in its theoretical aspect in that a critical realist perspective of disability and embodiment provides an understanding of how trauma is experienced by youth, internally in terms of the socio-psychological impact and externally in terms of structural barriers. In addition, the data is rich as the RES and the participants are well versed in trauma-informed work and a good rapport was established during the interviews.

It should also be noted that the study presents the following limitations: 1) the experiences of youth are presented from the perspectives of the workers at RES; youth participation in my study would have provided an in-depth understanding of their experiences of trauma. Despite this limitation, workers’ views of intervention and interaction with youth is of crucial benefit to social work practice and research. Similarly, the research methods do not allow for identifying fully how the trauma
experienced by the youth fits the developmental trauma disorder diagnostic criteria, as some items, such as duration of symptoms, can only be evaluated on an individual basis. Moreover, ethnography was used in a general sense as a research method as it allows for flexibility, however, this study it is not a typical ethnography, where the researcher immerses him/herself in the research and actively engages in approaches such as participant observation.

However, my familiarity with RES enhanced my research as I had an understanding of the agency and its culture, but I also had to guard against bringing my preconceived ideas about the experiences of the caseworkers and their perspectives to my research.
CHAPTER FIVE: FINDINGS

My findings reflect two major themes: 1) youth presentation and 2) the practice of the caseworkers who work with traumatized youth. The theme of youth presentation consists of five sub-themes that emerged from the data: background of the youth, sources of trauma, consequences of trauma, how the youth are given multiple diagnoses, and the perspective on the youth’s resilience and strengths.

Youth Presentation

Background of the youth

The caseworkers’ descriptions of the youth at RES provided an understanding of the different components of their backgrounds: the communities where they come from, their familial backgrounds, and their experiences with child welfare institutions.

Communities

The children and youth attending treatment at RES’s group homes come from a variety of communities across Canada, including northern territories (Yukon, Nunavut, and Northwest Territories), isolated rural communities, First Nations reserves (mainly within Saskatchewan), and eastern Canada, particularly Newfoundland and Labrador. As reported by the clinical caseworkers, the youth come from communities where they have often been exposed to a variety of risk factors.

Exposure to violence within their communities appears to be a normalized experience. According to Jane, one of the caseworkers:

Kids that we worked [with] who have been involved in other criminal activities, stealing vehicles, violence, offences against other people, and you know, and things that lots of times that’s the culture that they have been raised in, and so...
They have been exposed to so much violence at a young age that it doesn’t faze them anymore.

Another caseworker, Carlos, added that when communities are isolated and have a dominant antisocial perspective, children are exposed to negative peer influence within their communities: “if an antisocial perspective is valued, then the peer group is likely going to have that type of influence or involvement.”

In addition, an inherent lack of resources and support services were identified as a key factor that leads the youth to engage in problematic behavior, such as drug abuse and legal involvement. As Kelly reported:

What brings them [the youth] to the program? . . . Issues in their home community, especially if they are smaller communities they just don’t have the resources to kind of take care of the kids and because they . . . need more supervision because of their level of cognitive functioning, and if they are not able to get that from their family, or whoever is taking care of them, sometimes it ends up that they’re getting into trouble with the law, or drinking, or doing drugs, or whatever else.

In summary, lack of community resources, exposure to violence, and other risk factors are the adverse elements that contribute to the youth’s exposure to trauma. These factors also create a challenge for successful discharge of the residential programs.

**Familial backgrounds**

Caseworkers also discussed how families present a complex environment for the youth and how that can include a chaotic/disorganized environment. Jane reported that “a lot of the parents also have experienced abuse. . . . The whole family is just so disorganized and there is no sense of what a healthy family should look like.” She added that children who come to RES have witnessed violence, experienced physical, emotional or sexual abuse, and have issues with boundaries and abandonment.
Intergenerational trauma was also identified as a problem for youth. Trauma has been passed down from one generation to another; some parents and grandparents of the youth at RES have suffered trauma due to being placed in residential schools and from being raised by someone who experienced trauma. Daniele stated: “kids end up feeling it, they end up growing up with those emotional traumas because they’re being raised by someone who had emotional trauma.” She added:

A lot of complex intergenerational trauma, hmm, you know when you talk about parents who’ve had the kids get taken away, it’s usually like the parent also had trauma and that history, and the grandparent had trauma, hmm, we have a lot of kids with First Nations backgrounds, and grandparents I have spoken to or parents I have spoken to were in residential schools, so . . . I mean there is huge complex histories of trauma that get passed down.

In summary, family members have their own challenges with trauma that are reflected in parenting difficulties and the home environment.

**Child welfare system**

Children and youth at RES have often been involuntarily involved in the child welfare system from an early age. The children often have experienced multiple placements in foster care. Carlos reports: “You look at someone who has been tossed around the child welfare system, and been to 25 different placements, been ripped from home to home to home.” RES tends to be a later option for treatment as it is more costly than other residential placements for the youth: “we tend to be because we are a high per diem placement, we tend to be not the first option, but the last option.”

Residential care within RES is viewed by the caseworkers as an environment for the youth that facilitates stabilization, transition into adulthood, and an opportunity to focus on trauma. Teresa commented: “a significant amount of youth in this program are here preparing to transition to independent adulthood, primarily because they don’t have
any other resources.” In some cases, the youth live in a group home for extended periods of time (three, four years) when they have cognitive disabilities and do not have alternative environments that provide the support that they need. As Kelly reported:

Length of stay in our house is generally, tends to be quite a bit longer than in the other houses. . . . I think the longest when I started, one boy who has been here at the Ranch like three or four years, hmm, and lots of the kids before I started here that have gone through this house specifically end up being at the Supported Living Program, until they are 20, 30 . . . because they do need that supervision, they don’t have the internal . . . whereas lots of the other kids in the units if they’re higher functioning they learn a little bit better and they’re able to kind of control their behaviors once they go home.

Youth that participate in residential programs at RES are generally involved with the child welfare system extensively during their early years of life, and residential programming is used an option when other placements have not been successful or their communities do not have the resources to provide them with the support that they need.

**Sources of trauma**

There was wide recognition among the clinical caseworkers that most of the children and youth that they worked with had experienced trauma. Myrtle noted that “a lot of my kids come in with a lot of complex trauma issues . . . that can range from domestic violence, to abuse, to parental addiction and all those kinds of pieces.” Daniele also commented: “almost all of them have a trauma history. Huge range, whether [it] is sexual, emotional, physical abuse.” Carlos added: “our youth have been exposed . . . generally speaking to more different types of trauma or experiences that a lot of people would face in their lifetime.”

According to their responses, the causes of trauma experienced by the youth include abuse (physical, sexual, emotional), chaotic home environments, separation from caregivers, multiple placements within the child welfare system, abandonment and
rejection from caregivers, parents with addictions, domestic violence, grief and loss, parents’ experiences of trauma, and community violence.

Trauma experienced within the home and familial environment includes exposure to various types of violence, a disorganized environment, grief and loss, and abandonment. Teresa stated: “particularly those who are long-term wards, which I’d say at least half of this program tends to be that way . . . they come from extremely dysfunctional family backgrounds . . . where they have been abandoned . . . possibly very early on.” Carlos, another participant, reported that for many children “there’s been parent-family conflict, there’s been significant trauma, there’s been is grief and loss issues, there’s substance abuse issues, either from the child or the environment they were living in.”

Experiencing separation from their families and caregivers, as well as multiple placements within the child welfare system, including placement and moves within group-home care, were clearly identified by the caseworkers as sources of trauma for most children at RES.

**Symptoms and consequences of trauma**

Response to trauma varied depending on individual, community, or contextual factors; in other words, behavior exhibited can be a reaction learned from their environment:

A couple of kids just really shut down, so when they’re upset their first go-to response . . . [is] to shut down, not respond to questions, not make eye contact. And I think that’s [what] was noticed by a few kids coming from the same community. (Daniele)

The effects of trauma identified in the data include certain emotional and physical responses, behavioral difficulties (e.g., substance abuse, aggression and reactivity, self-
harm), and difficulties with relationships (e.g., affected self-esteem and identity, poor social skills, problems with attachment, and protective behavior).

Emotional signs of trauma exhibited by the youth in the RES group homes included difficulties in sustaining attention, hyperactivity, reactive behavior, hyper-vigilant behaviour, anxiety, an inability to modulate/verbalize emotions, immobilization and withdrawal. Jane reported: “if they are still experiencing very acute symptoms . . . it can affect . . . their attention . . . they can’t focus at school, they are very hyperactive, I mean hyperactivity and inattention . . . there are so many things that can cause them.” Daniele added, “hyper-vigilance, and that’s one [of] things that we notice with a lot of our kids, one of the kind of clinical presentations I guess is them being always on, and always aware, and always scanning the environment.” Another caseworker described the state of alert combined with difficulty verbalizing emotions:

One boy . . . he is constantly like on edge and anxious, and he can’t ever say what’s wrong, or what he is thinking or what he is feeling like he can’t identify any feelings, and hmm, but you can tell when you are looking at him if he is like just like tense. (Kelly)

Physical signs of trauma that are present among the youth in residential treatment are disturbed sleep and appetite. Trouble falling asleep seemed to be a general problem among the youth. In some cases, they have been prescribed sleep aids, and in other cases the difficulties with sleep were associated with side effects of medications. Moreover, nighttime could be difficult as it is a time that can remind the youth of their past trauma. Carlos noted that “they’re on stimulant medication, so their appetite is already affected and they are reporting they are not sleeping, but we have had kids who they’re not on any medication, and . . . their eating is affected, and their sleeping is affected.”
Overeating, hoarding food, craving sugar, and withdrawal accompanied by lack of appetite characterize some of the conduct observed among the youth, according to Kelly.

Use of drugs was seen by the caseworkers as a coping mechanism of the youth, which can act as a temporary way of masking or numbing emotional pain. This can be the only available option for dealing with emotions from trauma if the youth do not have supports or access to healthy recreational activities. As Daniele explained:

I think masking feelings, masking emotions, pushing things down by using is really . . . the most common connection that I see . . . I think often when it gets to a heavy use point is not wanting to deal with what’s going on, and not having any other options. Maybe not having anyone to talk to, back home . . . not having other activities to get their mind off of things.

Self-harm (e.g., cutting) is another presenting behavior of the youth, and this type of conduct varies depending on the group-home and the group dynamic. Sometimes when one youth starts self-harming, other will follow. Daniele reported, “we also find sometimes because it’s group living, we find when one person starts cutting . . . there . . . [are] a few others who do as well.”

The participants also reported youth aggression and reactivity. Reportedly, aggression manifested itself in the form of re-enactment of the trauma and other times as a learned behaviour engaged in to release stress. Jane noted: “a young boy who was quite cognitively delayed and really not able to express himself and so he would, we saw a lot of behaviors of aggression, hmm, because he had been so badly traumatized.” Daniele also aptly noted, “we’ve got a few kids who really have issues expressing their anger in constructive ways, the anger itself isn’t necessarily bad, but whether they get violent or aggressive or damaging property, that would come up as well.” Daniele concluded that
the group-home environment sometimes acts as a catalyst of this reactivity: “when one kid would be off, some of them would . . . also become quite either defiant or aggressive, or because that’s, maybe the kind of environment that they grew up in.”

Youth engagement in sexually inappropriate behaviors can be present as a consequence of past sexual abuse or can be related to low cognitive functioning. There are specific group-homes at RES that focus on this behaviour as the main presenting issue. They offer specialized treatment, as Carlos explained: “the youth that come into this program . . . usually end up qualifying with sexually inappropriate behaviors, or sexually intrusive behaviours. . . . And in a lot of cases they have a sexual trauma [in their] past.”

Problems with attachment and distrust in relationships are a common clinical presentation of the youth, due to the nature of the abuse that they have experienced in their lives. Disrupted attachment affects their feelings of safety, “especially if . . . they don’t really trust, like I think the one boy who used to sleep in his doorway . . . he liked all the staff but he was always . . . cautious of you, and didn’t . . . really trust anybody” (Kelly). Teresa added, “it is pretty difficult to work with them when they’re not prepared to develop strong meaningful relationships with people because of how much they’ve been hurt by others.” In summary, trauma happens in the context of relationships, which create relational difficulties. At the same time, building safe and healthy connections is an important part of the practice at RES as discussed later in this chapter.
**Areas of impairment**

The caseworkers were asked to reflect upon different areas in the life of the youth that were affected by trauma. These areas include familial, health, legal, peer, educational, and vocational.

Family is frequently the context in which trauma occurred for the youth when they were children, sometimes from very early in life (e.g., in utero exposure to alcohol or drugs). When children are removed from their families by the child welfare system because of concerns for their safety, their trauma is exacerbated by being separated from their family, having mixed feelings about their family, and experiencing feelings of abandonment. Kelly noted: “lots of anxiety about family, usually, yeah feeling like they’ve been abandoned.”

When trauma happens within the family environment, the youth are hesitant to talk about it, not only because it is a painful issue, but also because they are protective of their families and telling someone else about the abuse they experienced at home is usually what separated them from their family in the first place. Daniele neatly captured the painful youth experiences of family separation:

I think they’re hesitant to talk, and hesitant to share those stories. . . . Partially because, a lot of the reasons that they’ve come to Ranch Ehrlo, they told someone bad that happened to them and then they got taken away. So I think there’s still that fear that if I tell you what actually happen[ed], then I can put my family in jeopardy.

The physical health of the youth was described by the participants as generally positive. Caseworkers reported that youth were healthy probably because of their young age and resilience. The participants noted that the health problems of youth were mainly physical with occasional concerns about mental health. For example, Daniele reported, “I
think sometimes when kids first come [to RES], there is usually a few things to be dealt with . . . dental work that needs to be done . . . a lot of kids are pretty resilient and they [are] still young so their health is okay.” Some health concerns are fatigue and a compromised immune system from being in a hyper-vigilant state, difficulties with sleep, consequences of high risk behavior such as substance abuse, and some dental issues due to hygiene habits.

Many of the youth in residential programming at RES have been involved with the legal system because of theft, violence, or sexual offences. These offences occur at times when the youth are struggling emotionally and can be precipitated by the use of substances. Daniele noted that

we definitely have a few kids who have legal involvement . . . it’s often the behaviors that come up, it’s the aggression or anger, threats [to] other people . . . and unfortunately it often happens at a time that the person is struggling, so a lot of the offenses are committed while . . . the youth are under the influence of alcohol or drugs.

The youth seem to have little regard for the legal system. Many have been involved in violent acts, which appear normal to them due to their exposure to community violence and negative peer influences, such as gangs. As Jane described: “lots of times that’s the culture that they have been raised in, and so . . . [it] is seen as normal. . . . They have been exposed to so much violence at a young age that it doesn’t faze them anymore.” They tend to not consider the long-term consequences of their legal charges because they anticipate living a short life, and so they continue accumulating legal charges. The caseworkers made two disconcerting comments. First, Carlos reported that “legal involvement tends to be quite regular and quite normalized. . . . I work with many kids who don’t anticipate living past the age of 18, so legal involvement isn’t
really a big issue” for them. Second, Teresa commented: “it’s difficult with some of them to really resolve all of their legal issues before they acquire a new legal problem.”

From the participants’ viewpoint, trauma also affected the youth’s relationships with their peers. The caseworkers mentioned that youth tend to have conflictual or negative involvement with their peers. For example, Jane noted that “there are . . . kids that really struggle with social skills, they have never seen them demonstrated positively, and so they don’t know how to, how to interact with other people.” Teresa provided further insight into the poor relationships the youth have with peers by stating that relationships with peers can be a source of conflict because of normalized violence and are often related to antisocial activities, such as gang involvement: “it’s just the age group and the environment within which we are working. . . . A lot of the peer groups have a lot of problems . . . where there is gang involvement, . . . violence, . . . the risk of exploitation for some of our girls.” However, the participants also noted that social skills can vary widely among the youth in residential care at RES. Some youth are very charismatic and are natural leaders while others have a difficult time making friends.

School can be a difficult environment for youth with poor peer relationships, and educational difficulties are common for youth who have experienced trauma. In some cases, the youth are able to focus and feel safe at school, particularly when they have positive peer relations. Educational challenges for youth manifest themselves in the form of absenteeism and low academic performance, as well as inappropriate behaviours. Regarding educational challenges for youth, Jane reported:

Maybe school has been a place where they can escape from the abuse that is happening at home, then school is a safe place for them, and they do well at school. . . . If school is another place where they are always getting in trouble . . .
not able to sit still, and they are struggling academically because they can’t concentrate . . . then school can even be an added trauma.

The previous quotation reflects that although the youth can present difficulties in various life domains, not all areas present impairments, and sometimes they can do well in areas like school.

Caseworkers also noted that the vocational experiences of the youth can be affected by their trauma and academic achievements. Jane noted:

If they’re still experiencing all the effects of the trauma. If the trauma is still affecting their day-to-day routine, then [that] is gonna [be] pretty hard for them to have a job . . . the anxiety, or inattentiveness . . . if they’re behind in school and they are not able to read, that is going to affect whether they can get a job in the future.

Other participants commented that the youth did not necessarily expect to ever have a job. However, at the same time having one could be an area of success. Specifically, Carlos reported that “it’s different for a lot of the youth but the majority of them really struggle to participate in any type of work or vocational practice . . . because it[’s] never something that they’ve had to accommodate, complete or engage in.” This shows how success and life expectations are relative, and that given the opportunities, youth can have new life options.

**Diagnoses**

Residents at RES are assessed at intake and placed in the group-home that is best suited to meet their needs. Each group home focuses on specific youth issue(s) or problematic behavior (e.g., sexually intrusive behavior, conduct disorder/defiance, drug use, reactive attachment disorder symptoms). Youth present multiple issue(s), symptoms and/or behaviours which include attachment issues, going AWOL (running away from care), ADHD, depression, anxiety, FASD, grief, substance abuse, eating disorders,
sleeping disorders. The youth referred may have a number of high-risk behaviours and diagnoses and in some cases, developmental or cognitive disabilities (e.g., autism) and PTSD. The caseworkers recognized that trauma was likely the reason for those presenting behaviors. “A lot of the reasons that are being referred are a lot of behaviors that they’ve seen back home . . . and then almost all of them have a trauma history. Huge range, whether [it] is sexual, emotional, physical abuse” (Daniele).

It is not uncommon for the youth to have been diagnosed before their arrival at Ranch Ehrlo and to be on previously prescribed multiple medications. It becomes a challenge to have an accurate assessment due to the multiple presenting behaviours, multiple placements, and the after effect of medications: Carlos stated:

In many cases when kids come here, they have already received several diagnoses . . . and they may have been placed on multiple medication . . . and they may have been medicated to be ADHD or ADD quite a bit, so they’re on stimulant medication, so their appetite is already affected and they are reporting they are not sleeping . . . Getting a clear picture, . . . I don’t even think it’s possible because we have already kind of put them through significant trauma by placing them here.

The presence of multiple diagnoses and multiple medication prescriptions for the youth is a key element identified by the proposers of DTD who argue that this complexity is not serving the treatment and recovery efforts for the youth well.

**Resilience and strengths**

According to participants, youth at RES are resilient. They are survivors of trauma, and they are able to overcome life challenges and lead healthy lives. Jane noted that kids are amazingly resilient. They have so many strengths and it just amazing sometimes what kids can live through and still be okay, you know live normal lives, so it is really, you know, it’s certainly not a death sentence . . . and there is definitely hope.
One way of fostering resilience for youth at RES is to encourage their family connections and support. Teresa stated that

even though that’s not a strong piece of the mandate in this program, it’s essential to the kind of work we do . . . building resiliency for that youth and their relationships to their families. . . . We know best practice is that a young person still has those connections, and the stronger they are, the better . . . obviously you wanna support most connections.

When working towards resilience and adaptation, it is important to consider the environment that the youth will be discharged to, as some behaviors that are considered negative in the context of residential treatment can be essential for life in some of the communities the youth live in. Carlos stated that

a few of them [the youth] are really kind of skewed perspectives on what’s appropriate and what’s inappropriate, and not necessarily like wrongfully, hmm there’s a few communities I have worked with where . . . violence is really appreciated, and if you can’t be tough . . . then you are not going to survive. . . . And it’s a consideration that you have to have, because when they do return to those communities, you could expose them to a lot more by kind of breaking that wall.

The previous excerpt reflects the complexity of the practice and the challenges that social workers face, on the one hand, working for a system that wants the youth to adapt to norms, while on the other, needing to respect the values and desires of the people that their profession serves.

The children and youth participating in residential treatment in RES present a variety of strengths. Recognizing them and building on their unique strengths becomes an essential component of treatment. The strengths identified in the youth by the caseworkers included gratitude, mindfulness, and a sense of humor. Carlos stated: “a lot of them have a really good sense of humor. . . . I think they’ve had to use at least one form or another [of humour] as coping.” For Kelly, resilience and strength were
demonstrated when youth had the ability to develop relationships, show generosity, and teach others. Other caseworkers, like Daniele, felt that resilience was developed when youth wanted to get better and had the ability to have fun.

**Practice**

The sub-question of this research refers to how the caseworkers and RES work with the youth that have experienced trauma. The findings linked to this question emerged as three sub-themes: the context of practice at RES, trauma-informed care, and challenges/worries.

**The context: Ranch Ehrlo**

Residential treatment at RES consists of four pillars: clinical, educational, recreational, and vocational. The goal is to provide the youth with a whole life experience and offer them positive life experiences in various domains. Jane described the treatment:

> At the Ranch we always pick a very holistic approach . . . teaching the youth skills that they can use to manage their emotions . . . giving them opportunities to participate in positive life experiences like sports, and art . . . giving them a really positive experience at school, so that they can have more confidence . . . trying to, to give them a wraparound approach where all their needs are being met, that they are in a safe home environment, so that they can really focus on whatever they need to focus on.

The caseworkers lead clinical work by providing counseling for youth, engaging in work with groups, as well as working with families and supporting the residential team. Caseworkers also are the main liaison with referring agencies and case managers and work directly with the youth in the form of counseling. Daniele noted:

> Clinically one thing I notice is kids not wanting to connect in a traditional counseling way. Sitting down in my office, having a chat is not something that’s comfortable for a lot of them . . . I’ve had to find a lot of ways to connect with
kids in different ways, so whether it’s we start with a game of foosball . . . going for a walk in the neighborhood. . . . I think trying to get creative is important.

Important to note is that each caseworker can be creative and flexible in their practice, and their background and skills contribute to shaping their interventions, such as counseling tools, therapeutic interventions, and their understanding of the front-line staff challenges. Teresa stated that “we all have such different education background or just different prior like job experience. . . . It’s nice that we are able to work differently with people.”

The support provided to the residential team by the caseworkers consists of communicating and emphasizing the clinical context of behaviours and how these relate to the trauma experienced by youth. Jane reported that “part of my role is training . . . a clinical perspective . . . to the staff so that they can . . . have the skills that they need to work with the youth . . . and helping them to understand where the kids are coming from.”

The caseworkers also facilitate group work, which involves a hands-on approach and can focus on different topics that would be a fit for their program. Some programs have specialized treatment groups, such as ones for self-esteem, healthy sexuality, and grief and loss. Myrtle noted that “there is like a hip-hop, self-esteem specific group, and a grief and loss specific group, so hmm so that makes more sense because then they are all the kids that are experiencing that same thing.” Group work tends to be creative and experiential and can utilize mindfulness as a tool for emotional regulation and for an experiential approach to therapy. Daniele added that “that sort of hands on experience seems to be pretty helpful. . . . We did one where you hold an ice cube in your hand . . .
and is supposed to [be] kind of [soothing] instead of self harming.” The youth are likely to remember and integrate the learning if these types of activities are used.

Family work is not the main focus in the residential programs; however, the caseworkers acknowledged the importance of working with the families of the youth in continuing and strengthening those relationships, as long as there are no safety concerns. For example, Teresa stated that “even though that’s [family work] not a strong piece of the mandate in this [particular residential] program, it’s essential to the kind of work we do.” Jane was cognizant that “no matter how much the parents have abused them or neglected them, they just still love their parents and they wanna be back with their parents, you know, so how can you make that work.”

There has been a shift at RES towards working more with the families, and the Family Treatment Program within the agency works together with the Residential Program in order to facilitate family reunification of some youth before they are discharged from the Residential Program. This can facilitate successful discharge as it works to strengthen and support the system that the youth will be going back to, as described by Daniele:

Prior to them discharging and going home they do a period of time with the Family Treatment Program, so that will focus a little bit more having all of the family in the same house, living there. . . . The staff actually get to work with the family altogether, and try to figure out how are we gonna work together as a family, what interactions are helpful, so that when a youth goes home…the parent knows the skills that the staff has been using some of the past year as we work with the youth.

In some cases, families are no longer able or willing to care for the youth due to problematic behaviors (e.g., sexual behaviors that place other family members at risk, cognitive disabilities that require high level of supervision), and in other cases families
are close to the youth and connected throughout the duration of the residential treatment. Some of the challenges in working with the families for the residential programs are time constraints, distance, and language barriers.

Education is another pillar of the residential programming. At the time of intake, the youth usually start with individualized educational programming at the Schaller Educational Centre, an RES educational facility located in Pilot Butte. At that school, youth are assessed academically. They work on achieving appropriate academic goals and are offered an environment that supports their emotional regulation (e.g., lots of breaks and adults that understand their emotional challenges). There are also RES classrooms situated within Regina Public School Board schools and youth can participate in mainstream classes depending on their individual abilities. The goal of offering individualized educational environments for the youth is to foster success and positive experiences with school. Myrtle summarizes:

A lot our kids tend to start out at Schaller. . . . [It is] individualized programming. . . . You are assessed right away, and you are doing stuff at your level, or if you’re say a 13 year old, but your skills are at grade 2 or 3 level, so you start, because you are wanting to foster that success. . . . Sometimes they start out in the community right away . . . if they are a local kid and school hasn’t been an issue and there aren’t safety concerns then that’s a possibility. . . . I mean the goal is always, you want to get them mainstream but some of them they might need a little more support before they can get there for different reasons.

The youth are presented with a variety of recreational options within the residential programming and also outside of RES, depending on their individual interests (e.g., voice lessons, soccer). The focus on recreation aims to offer opportunities for the youth to connect at the community level, provide experiences to build on social skills and self-esteem, and be a physical outlet. Also, recreation allows the youth to form prosocial attachments and feel successful. It is hoped that some elements of this can be
maintained upon discharge, although lack of resources within communities can be a challenge. Daniele reported that “they’re out in the community, he’s made friends in the team, he feels a sense of accomplishment every time he goes, he gets physical activity and get the energy from, so that ends up being the . . . motivator for treatment.” Kelly added that “working on developing some interests with them . . . and, some skills, and some self-esteem . . . and making friends in a positive environment and seeing if they like it.”

The vocational pillar compliments the other aspects of residential programming. It is aimed at providing the youth with work experience and skills related to job searching (e.g., resume writing, interview preparation). In some cases, vocational opportunities are utilized as an alternative to attending school. Teresa noted: “I’ve also had young people in this program where they are not attending school at all and they’re working, or in some sort of . . . Life-Skills Program.” RES has a Community Vocational Education Program (CVEP) as an internal resource to facilitate work experience and training for the youth.

**Trauma-informed care**

Trauma-informed care is a perspective that facilitates the understanding and practice of traumatized youth at RES. The caseworkers believed that most of the youth who enter residential treatment have experienced trauma. Therefore, having an understanding of trauma is fundamental for their practice with the youth. Although resolving the trauma is not necessarily a goal for treatment at RES, being aware of a traumatic past means recognizing the reason behind a given problematic behavior and
understanding the backgrounds of the youth, their culture, and their values. Jane described the notion of trauma-informed care in the following way:

It is really easy to become very frustrated with the behavior . . . but . . . ok this is where they are coming from, this is what they have experienced . . . that kind of puts it in context to understand why they are behaving the way they are behaving. . . . It helps the staff to be a little more patient and understanding with some of the behaviors, and then give them a different kind of lens to see things through.

In addition, it is paramount to comprehend how trauma has affected the individual, including what are their particular triggers and responses to trauma. Carlos stated that “being aware of what trauma is, how people respond [to] traumatic behaviors, what a trigger is, what the crisis cycle is, what the best approaches are for dealing with somebody who has experienced trauma, and is exhibiting trauma response.” In summary, having an understanding of trauma in general terms, as well as how it affects a youth in particular, is important for the caseworkers in their practice within the residential programs.

Avoiding re-traumatization becomes an important consideration during treatment. This is a challenge given that youth continue to be institutionalized within the child welfare system and that physical restraint is used in the group-homes on occasion. There is also a risk of re-traumatization of the youth when they retell prior traumatic events. The caseworkers interviewed noted that residential treatment is not always the best approach when working with youth who have experienced complex trauma and suggested that working with in-home treatment (e.g., family preservation programs) would be ideal, as would reducing the number of residents for each group-home (currently about 10 youth are placed together in each group-home at RES). Caseworkers
also tried to minimize moves within residential treatment at RES as a way to avoid causing further trauma. As Myrtle stated:

For any child to be in residential care, that’s not ideal . . . some of the things that we do, is that creating more trauma for the child, so multiple moves, or physical interventions, even when they might be necessary to prevent that harm, any time you put hands on a kid, that’s re-creating that trauma and it’s bringing things back up.

The efforts to minimize moves among the residential programs at RES are in line with the focus on establishing and maintaining significant relationships for the youth, as described below.

Residential treatment at RES encompasses a focus on relationships, skill building, establishment and maintenance of a safe and predictable environment, and developing skills in regard to emotional regulation. Establishing relationships with the youth is a key component of practice because it can help to build trust with the youth, many of whom have experienced broken relationships in their past. Daniele commented that “one of the biggest things we do overall is we make relationships and connections with youth so that they feel comfortable.” Having a meaningful connection with youth facilitates the therapeutic process, develops trust, and encourages caseworkers and youth to be aware of strengths and to build on those. Due to the interpersonal nature of the youth’s trauma, their attachment is often affected; therefore, developing a relationship with the youth is identified as the main challenge in the residential practice. Facilitating a connection between the youth and family members is also a critical element of treatment when possible, as it enables the youth to feel more comfortable during their stay in the group-home and fosters relationships which will be critical after they have been discharged.
Skill building is another key component of practice, which comprises relationships and emotional regulation within educational, recreational, and vocational settings. The importance of skill building for youth is clearly reflected in Jane’s statement: The caseworkers job is “teaching the youth skills that they can use to manage their emotions, . . . to think before they act, cognitive behavior strategies . . . [giving] them opportunities to participate in positive life experiences.” Myrtle noted that building relationship skills with their peer group in the youth is a central focus of the work due to the nature of the group-home; “we do a lot of work with the peer group. . . . There is a lot of stuff that comes up . . . there is a lot of opportunity for problem solving, and trying out new social skills.” The practice in group homes at RES places a focus on establishing a “living therapy” environment that facilitates trauma treatment by providing a safe and predictable setting and working on structure and routines. For Jane “[the youth] need to feel safe. . . . This might be one of the first times that they have regular meals and a regular place to sleep, and they have their own bedroom.” Providing an environment that is predictable and feels safe to the youth allows for working on emotion regulation.

Emotion regulation is a means of addressing behavior as the starting point of resolving trauma and dealing with anxiety, panic, or anger, as Jane noted:

We start with the behaviors first . . . even though that’s just the tip of the iceberg . . . that’s kind of an easy place to start, especially for somebody who, you know, isn’t able to express themselves or is really anxious, or is, really just can’t address the trauma right away, we start with those external things, we start with educational pieces, and then we kind of work inward, and . . . eventually the goal is to . . . peel away those layers and get to the root of it, which is their trauma.

This emotion regulation can take the form of co-regulation, and the goal is for youth to work towards self-regulation by having the opportunity of working on emotional regulation skills. Myrtle noted that “a lot of [the work] is the emotion-
regulation piece . . . so how do I manage my anxiety, how do I manage my anger, how do I manage my stress, or the panicking.” As the caseworkers described how their practice was trauma informed and some challenges they faced in that respect, they also expressed some difficulties and concerns about other aspects of their work with the youth, which are described in the following section.

**Challenges and worries**

The caseworkers talked about the challenges and concerns in their practice: the need for self-care, limited time for proactive interventions, and the successful discharge of the youth from the program. These three ideas are discussed in more detail below.

Self-care is a challenge due to the type of histories that the youth have. It is important for caseworkers and staff to take the time to process what they learn from the youth’s stories and to know that it is normal to have emotional reactions to them. For example, Daniele stated: “I think it’s hard not to bring things home with you.” In addition, staff members are not always prepared for the challenges of working in residential care; therefore, investing in training and the wellbeing of employees becomes relevant as explained by Carlos:

If you are restraining a young person that can be very traumatic, and if you are not ensuring that your staff are healthy, unfortunately that”[s] gonna impact them which is going to impact the young people they work with. . . . I don’t know that we put enough emphasis in training and preparing people [that] . . . where our resources are allocated in regards to ensuring that the staff are healthy and engaged with the young people to do the best job they can.

Other participants identified challenges, such as limited time for developing programming and proactive interventions. Myrtle noted that “your focus tends to be more so on . . . the crisis that really needs your attention.” Finding appropriate
educational and treatment resources to work with individuals who have cognitive disabilities can be another challenge, as Kelly explained:

Something that I find difficult is finding something that’s age-appropriate because we do have 16 to 17 year-olds but maybe they are only understanding language at the like a 6 year old or 7 year-old, so . . . a lot [of] having to modify things, and it’s difficult, and really knowing if they get it.

Another concern raised by the participants was related to successful youth discharge from the program. Participants were concerned that the youth would not have the support from their families and communities that they needed and also that the youth would become involved in unhealthy activities and environments, exposing them to more trauma. As Kelly said, “I’m always worried when they leave . . . hmm that they’re gonna end up either victimizing, victimized, or like in jail,” Kelly went on to say:

We can always make recommendations as to what they need, which we do every time they leave . . . but even though we make those recommendations we can’t say whether or not they’re followed, and they might be going to . . . a place that for sure they are not gonna get that [help] based on the resources of the community.

In conclusion, the challenges discussed by the caseworkers about their practice seem common for social work and explain the tension between providing services that are client centered in the context of an organization such as RES and considerations related to post-treatment environment.
CHAPTER SIX: ANALYSIS AND DISCUSSION OF FINDINGS

In relation to the first research question about the developmental trauma experiences of the youth in residential care at Ranch Ehrlo, the clinical caseworkers spoke about how the familial and community background of the youth and their multiple placements within the child welfare system shape their experiences of trauma. A number of causes and consequences of trauma were identified by the research participants, which largely correspond to the DTD diagnostic criteria (see Appendix A). There were some items of DTD criteria that are beyond the scope of this research because the nature of those categories (for example, the duration of exposure to trauma or the number of combined trauma consequences corresponding to sections E and F) means they need to be evaluated on an individual basis. The following table summarizes how the findings of the research correspond with the DTD diagnostic criteria. The items described according to the data findings include exposure to the trauma (section A), symptoms and consequences of the trauma (sections B, C, and D), and areas of impairment (section G).

Table 1: DTD and research data.

<table>
<thead>
<tr>
<th>Developmental Trauma Disorder Criteria</th>
<th>Disorder Criteria Manifested in RES Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: Witnessed multiple or prolonged events of at least one year (time of exposure not assessed in the research but likely to meet the criteria)</td>
<td></td>
</tr>
<tr>
<td>A1: Exposure to interpersonal violence</td>
<td>*exposure to multiple traumas: emotional, physical, sexual abuse; witnessed violence; neglect; chaotic home environment</td>
</tr>
<tr>
<td>A2: Disruption of protective caregiving</td>
<td>*separation from families experienced by all youth</td>
</tr>
<tr>
<td></td>
<td>*multiple placements within the child welfare system for many youth</td>
</tr>
</tbody>
</table>

B Affective and Physiological Dysregulation
<table>
<thead>
<tr>
<th>Developmental Trauma Disorder Criteria</th>
<th>Disorder Criteria Manifested in RES Youth</th>
</tr>
</thead>
</table>
| B1 Inability to modulate, tolerate, or recover from extreme affect stages | • immobilization and withdrawal behaviours  
• difficulty modulating/verbalizing emotions when youth are afraid or angry |
| B2 Disturbances in regulation of bodily function | • difficulties related to sleep: difficulty falling asleep and staying asleep; sleeping less than what is considered normal for their age  
• affected appetite: overeating, decreased appetite, sugar cravings  
• over-reactivity  
• difficulty with transitions and following daily routines |
| C Attentional and behavioral dysregulation, including at least three of the following: (number of categories not assessed in the research but likely to meet the criteria) | |
| C1 Preoccupation threat | • hyper-vigilant and anxious behavior is common among the youth |
| C2 Impaired capacity for self-protection | • risk-taking behaviors such as sexual and drug use  
• thrill-seeking behavior such as gang involvement |
| C3 Self-soothing | • use of drugs in order to cope with emotional pain |
| C4 Self-harm | • reactive self-harm as a behavior that occurs when emotional pain is present  
• reactive self-harm in the context of a group home when other youth start self-harming |
| C5 Goal-directed behavior | • inattention and difficulty focusing on tasks |
| D Self and Relational Dysregulation, including at least three of the following: (Number of categories not assessed in the research but likely to meet the criteria) | |
| D1 Preoccupation with safety of others | • parentified behaviors, preoccupation with protecting caregivers  
• difficulty with family reunion after separation |
| D2 Negative sense of self | • affected self-esteem  
• negative sense of self  
• short life expectation  
• guilt and shame |
| D3 Distrust of close adults and peers | • difficulty trusting adults and caregivers  
• defiant behavior |
| D4 Reactive physical or verbal aggression toward peers, caregivers, or other adults | • aggression and reactivity  
• re-enactment of the trauma or a learned behavior |
| D5 Inappropriate intimate contact | • sexually intrusive behaviors evident in some of the youth. |
| E Posttraumatic Spectrum symptoms (PTSD). The child exhibits at least one symptom in at least two of the three PTSD symptom clusters B, C, and D. Not assessed in the research but likely to meet the criteria. | |
Developmental Trauma Disorder Criteria | Disorder Criteria Manifested in RES Youth
--- | ---
**F Duration of Disturbance** of at least six months of B, C, D, and E. Not assessed in the research but likely to meet the criteria.

**G Functional Impairment-Disturbances** in at least two of the following areas:
(Number of categories not assessed in the research, but likely to meet the criteria)

| G1 Family | • ambivalent feelings towards family  
• feelings of rejection and abandonment  
• anxiety about reunification with family  
• protective of family and not wanting to discuss trauma that happened at home or at the hands of a family member |
| G1 Health | • some physical concerns but no chronic conditions  
• dental issues  
• physical health of the youth deteriorates or they abuse substances when mental health concerns arise  
• youth seen as resilient in terms of health |
| G3 Legal | • legal involvement is normalized  
• general disregard for the legal system, linked to antisocial values  
• long term consequences of legal involvement not recognized as youth do not anticipate living a long life  
• legal charges are accumulated, making it difficult to resolve legal charges |
| G4 Peer Group | • anti-social perspective is often valued  
• peers are a source of reactive-aggressive behavior  
• gang involvement is present in some cases  
• under-socialization and lack of social skills needed to establish friendships |
| G5 School | • some youth working at lower grade level  
• problems with literacy  
• problems with school attendance in the past  
• for some youth, an area where they can focus and do well |
| G6 Vocational | • some youth able to sustain employment |

The second research question pertains to the views and practice of the caseworkers who work with youth who experience trauma.

In regards to practice, according to the research participants, the focus of the treatment of the youth in the Residential Program at RES is working on the behaviors
that brought them into the program in the first place, which includes working on emotion regulation, the provision of a safe and predictable environment, building social skills, and establishing relationships with significant adults. Ranch Ehrlo has a variety of resources in clinical, educational, recreational, and vocational areas in order to provide the youth with a holistic treatment approach and the opportunity for positive life experiences. Caseworkers drew attention to the fact that their clinical practice involved nontraditional approaches to counseling, such as connecting with the youth in more informal settings and during everyday activities. The establishment of a trusting relationship with the youth is essential for the therapeutic relationship, and it presents as the main challenge, as the nature of the trauma that the youth have experienced often affects their ability to trust and establish relationships with caregivers. The research participants also emphasized that being creative and utilizing techniques such as mindfulness were central to their practice.

Although not a goal of residential treatment at RES, addressing trauma is an important preoccupation of the caseworkers. They are concerned that if trauma remains unresolved, the youth will have life-long difficulties because of it. All the research participants had knowledge of complex trauma and spoke about trauma-informed care. The caseworkers acknowledged that trauma, along with social risk factors, was the cause of the problematic behaviors for which the youth were referred to RES, and they hoped that their clinical understanding of trauma could inform the work at the agency: “I hope that at least that’s what we are moving towards, is having [knowledge of] trauma inform all of the work we do” (Daniele). Having a trauma-informed model of care also meant
avoiding re-traumatization, which includes minimizing placements and physical restraints in residential treatment.

In terms of the views of trauma that affects the youth, the caseworkers discussed the issues of normalcy, success, stigma related to mental health, and considerations of resilience and strengths.

The caseworkers indicated that normalcy and success are relative and that values and life expectations of the youth must be considered in the context of residential treatment. In addition, the traumatic experiences and other life difficulties that the youth have experienced must be taken into account; the treatment expectations need to be realistic and adjusted to reflect the goals of the youth to allow them the opportunity for growth.

Because mental health difficulties are stigmatized and blame is placed on the individual, the conduct of youth at RES is always defined by the public as problematic behaviour. Understanding the societal definitions of youth behaviour can help caseworkers facilitate treatment of youth who are traumatized by addressing the individual’s shame and blame. This type of treatment can be empowering for the youth.

The youth suffering from developmental trauma were seen as resilient by the caseworkers. Despite having complex trauma histories and experiences, trauma was not always impairing for the youth. The caseworkers indicated that the youth had numerous strengths that contributed to their coping and adaptation. Treatment at RES facilitates fosters resilience in the youth by providing supportive relationships and environments. Post-discharge supports and environments remain a challenge, and focusing on working with the families of the youth is a way to collaborate on this.
CHAPTER SEVEN: CONCLUSIONS

My study has implications that are crucial to social work theory and practice. Theoretically, my study adds to our understanding of how to include DTD and a critical realist perspective of disability as an innovative approach to practicing social work. My research on developmental trauma explains a very complex but common issue for marginalized children and youth. Although not all categories of the DTD diagnostic criteria were assessed in detail from the responses of the caseworkers, the experiences and behavior of the youth in residential care at RES correspond with the DTD diagnostic criteria, which include exposure to abuse, violence, separation from the caregivers, and multiple residential placements. Taken together, these experiences appear as common among the youth that attend residential treatment at RES. The effects from trauma experienced by the youth are described in detail in the Findings chapter and are consistent with DTD as well as the existent literature on trauma.

A critical realist perspective of disability informs the issue of trauma experienced by youth according to the caseworkers because it involves medical aspects, societal factors, and embodiment. The DTD diagnostic criteria reflects the medical view of disability in that it focuses on the symptoms exhibited by individuals. It can contribute to more accurate diagnoses for the children and youth who suffer from trauma and are stigmatized for their behaviors. However, there are themes that emerged from the data that are external to the DTD diagnostic criteria. This speaks to the complexity of trauma; societal factors such as poverty, lack of recreational and educational opportunities for youth, parents struggling with their own trauma histories, lack of supports for parents, multiple child welfare placements, and current medical approaches that tend to offer
multiple diagnoses and medications to the youth in order to control behaviors also contribute to trauma. In terms of embodiment, societal contributors to trauma and the particularity of how an individual experiences it is reflected on their bodies and results in illnesses or symptoms, such as those of developmental trauma disorder.

The present study also contributes to the emerging discussion of the applications of DTD in social work practice and the need to enhance interdisciplinary work (i.e., to collaborate with psychiatry, psychology, and medicine), which will help to conceptualize how trauma manifests itself within the youth population. The present study offers analysis of how the DTD framework can inform the understanding of and practice with traumatized youth. Developmental trauma understood from the perspective of critical realism also aligns with social justice, a stance that is critical to social work practice because it takes into account social factors of inequality and discrimination that can negatively add layers of oppression to the experiences of traumatized youth.

Future research could involve case studies that account for DTD diagnostic categories that were not possible to convey by interviewing practitioners (see Table 1). Further research would contribute to understanding the problem in the Canadian context as most of the research on the topic of trauma emanates from the United States.

This research presents RES caseworker’s understandings of trauma experienced by youth. Moreover, considerations that avoid re-traumatization of the youth in residential care are discussed. Practical considerations of this research involve bringing forward the knowledge of clinical caseworkers and how they practice with youth at RES. Implications for social work speak to professional competency, social justice, and opportunities for interdisciplinary perspectives. In particular, issues of social justice will
require social work to consider innovative ways to provide services to youth in their jurisdictions, which would mean minimizing removal of youth from familiar social environments, an experience that can be traumatizing in and of itself. Providing services to youth within their communities is yet to be explored in social work research, but necessary as it has important policy and program implications that would be beneficial to families.
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biopsychosocial experiences “map” onto developmental trauma disorder criteria?


Appendix A: Developmental Trauma Disorder, Diagnostic Criteria

Consensus Proposed Criteria for Developmental Trauma Disorder (From van der Kolk, 2014, pp. 265–266)

A. Exposure. The child or adolescent has experienced or witnessed multiple or prolonged adverse events over a period of at least one year beginning in childhood or early adolescence, including:

A. 1. Direct experience or witnessing of repeated and severe episodes of interpersonal violence; and
A. 2. Significant disruptions of protective caregiving as the result of repeated changes in primary caregiver; repeated separation from the primary caregiver; or exposure to severe and persistent emotional abuse.

B. Affective and Physiological Dysregulation. The child exhibits impaired normative developmental competencies related to arousal regulation, including at least two of the following:

B.1. Inability to modulate, tolerate, or recover from extreme affect stages (e.g., fear, anger, shame), including prolonged and extreme tantrums, or immobilization,
B. 2. Disturbances in regulation in bodily function (e.g., persistent disturbances in sleeping, eating, and elimination; over-reactivity or under-reactivity to touch and sounds; disorganization during routine transitions).

C. Attentional and Behavioural Dysregulation: The child exhibits impaired normative developmental competencies related to sustained attention, learning, or coping with stress, including at least three of the following:

C. 1. Preoccupation with threat, or impaired capacity to perceive threat, including misreading of safety and danger cues,
C. 2. Impaired capacity for self-protection, including extreme risk-taking or thrill-seeking,
C. 3. Maladaptive attempts at self-soothing (e.g., rocking and other rhythmical movements, compulsive masturbation,
C. 4. Habitual (intentional or automatic) or reactive self-harm,
C. 5. Inability to initiate or sustain goal-directed behavior.

D. Self and Relational Dysregulation. The child exhibits impaired normative developmental competencies in their sense of personal identity and involvement in relationships, including at least three of the following:

D. 1. Intense preoccupation with safety of the caregiver or other loved ones (including precocious caregiving) or difficulty tolerating reunion with them after separation,
D. 2. Persistent negative sense of self, including self-loathing, helplessnessworthlessness, ineffectiveness, or defectiveness,
D. 3. Extreme and persistent distrust, defiance or lack of reciprocal behaviour in close relationships with adults or peers,
D. 4. Reactive physical or verbal aggression toward peers, caregivers, or other adults,
D. 5. Inappropriate (excessive or promiscuous) attempts to get intimate contact (including but not limited to sexual or physical intimacy) or excessive reliance on peers or adults for safety and reassurance,
D. 6. Impaired capacity to regulate empathic arousal as evidenced by lack of empathy for, or intolerance of, expressions of distress of others, or excessive responsiveness to the distress of others.

E. Posttraumatic Spectrum Symptoms. The child exhibits at least one symptom in at least two of the three PTSD symptom clusters B, C, & D.

F. Duration of disturbance (symptoms in DTD criteria B, C, D, & E) at least 6 months.

G. Functional Impairment. The disturbance causes clinically significant distress or impairment in at least two of the following areas of functioning:
   -Scholastic
   -Familial
   -Peer Group
   -Legal
   -Health
   -Vocational (for youth involved in, seeking or referred for employment, volunteer work or job training)
Appendix B: University of Regina Ethical Clearance

Research Ethics Board
Certificate of Approval

Principal Investigator
Susana Prado Becerra

Department
Social Work

REB# 5051213

Supervisor
Dr. Daniel Kikulwe

Funder(s)
Unfunded

Title
The developmental trauma experiences of youth living in group homes at Ranch Ekri: The perspective of clinical case workers

Approvals
Application for Behavioural Research Ethics Review
Research Information Letter
Participant Consent Form
Preliminary Interview Questions

Certificate
The University of Regina Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol, consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

Ongoing Review Requirements
In order to receive annual renewal, a renewal report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: http://www.uregina.ca/research/faculty-staff/ethics-compliance/human/forms1/ethics-forms.html

Dr. Larena Hoeber, Chair
University of Regina
Research Ethics Board

Please send all correspondence to:
Research Office
University of Regina
Research Ethics Board
Regina, SK S4S 0A2
Telephone: (306) 585-4175 Fax: (306) 585-4803 research.ethics@uregina.ca
Appendix C: Ranch Ehrlo Society Ethical Clearance

December 1, 2015

Ms. Susana Prado
60-5004 James Hill Road
Regina, SK S4W 0E8

Dear Ms. Prado

I am pleased to inform you that the attached named research project was reviewed by the Research Review Panel for Ranch Ehrlo Society and found to be acceptable. The Research Review Panel has recommended the research project involving Ranch Ehrlo caseworkers be approved as submitted and without further revision. The principal and assistant investigators are responsible for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out as described in the proposal submitted.

Any significant changes to your proposed method, participants, and consent procedures should be reported to the President/CEO of Ranch Ehrlo Society.

Good luck with your research. I look forward to reviewing the results of your project.

Sincerely

Andrea Brittin
President and CEO

Encl.
Appendix D: Research Information Letter

Dear Clinical Caseworker:

I am attending a Masters of Social Work at University of Regina, and I am conducting a study this Fall 2015. The study is entitled “The developmental trauma experiences of youth living in group-homes at Ranch Ehrlo: The perspective of clinical caseworkers”. This study aims to understand the perspectives of caseworkers, working with youth experiencing complex trauma. This research aims to contribute to our understanding of trauma informed care when working with youth.

Please be advised that the research has been reviewed and approved by the Research Ethics Board at the University of Regina.

The data collection will consist of interviews with caseworkers that work with youth living in Ranch Ehrlo Society’s group-homes. The durations of each interview will be around one to one-and-a-half hours. All interview information will be used in a confidential manner, which means that names and other identifiable information will not be used in the reporting or dissemination of this research.

Participation on this research is voluntary and participants are free to withdraw from the research at any time. Participation/withdrawal from this study will not affect your employment with Ranch Ehrlo Society. Please review the “Participant Consent Form” provided, which informs of the rights and confidentiality to the participants.

I would very much appreciate your participation on this study. Please accept my most sincere thanks in advance for your consideration of this matter. If you have any questions about this study, you can contact Susana Prado, student and researcher by email at susanaprados@gmail or prado20s@uregina.ca, or by phone at (306) 519-2328.
Appendix E: Participant Consent Form

PARTICIPANT CONSENT FORM

**Project Title:** The developmental trauma experiences of youth living in group homes at Ranch Ehrlo: The perspective of clinical caseworkers

**Researcher(s):** Susana Prado, Faculty of Graduate Studies, graduate student, Department of Social Work, University of Regina, (306) 519-2328, susanapradob@gmail.com, prado20s@uregina.ca

**Supervisor:** Daniel Kikulwe, Faculty of Social Work, (306) 585-4588, daniel.kikulwe@uregina.ca

**Purpose(s) and Objective(s) of the Research:** To understand the perspective of caseworkers, working with youth experiencing complex trauma and residing in Ranch Ehrlo Society's group homes, using the developmental trauma disorder perspective.

**Procedure:** The data collection will take place in various locations of Ranch Ehrlo Society, during the period of the fall semester of 2015. This will consist of interviews with caseworkers. Each participant will be interviewed once, and the duration of the interview will be around one to one-and-a-half hours. Please feel free to ask any questions regarding the procedures and goals of the study or your role.

**Potential Risks:** There is a possibility that participants may experience some feelings of discomfort during the interview. If you experience discomfort during or after the interview, you have the option of accessing support from your clinical director, counseling/support via Ehrlo Counseling, or counseling via the provider of your choice through your employee benefits. You also have the option of not discussing any areas of the interview that made you feel uncomfortable.

**Confidentiality:** Your information will be confidential, which means that there will be no link between the information collected and your identity. The research data will be stored in a secure place and only the researcher and academic supervisor will have access to it. The information will be stored for five years after the elaboration of the final report at the University of Regina by the research academic supervisor. After this, all data will be deleted/destroyed.

**Right to Withdraw:** Your participation on this research is voluntary and you are free to withdraw from the research at any time before January 31st, 2016. The researcher has no authority or power at Ranch Ehrlo, and your participation/withdrawal from this study will not affect your employment with Ranch Ehrlo Society. Should you wish to withdraw, please contact the researcher by phone or email. If you withdraw from this study, your data will be deleted from the research project.
Follow up: To obtain results from the study, please contact the researcher by phone or email. If you would like, provide us with an email or mailing address in order to receive a summary of the research findings.

Questions or Concerns: If you have any questions or concerns please contact the researcher using the information at the top of page 1 of this form. This project has been approved on ethical grounds by the University of Regina Research Ethics Board. Any questions regarding your rights as a participant may be addressed to the committee at (585-4775 or research.ethics@uregina.ca).

SIGNED CONSENT

Your signature below indicates that you have read and understand the description provided; I have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the research project. A copy of this Consent Form has been given to me for my records.

______________________________      _______________________
Name of Participant            Signature            Date

______________________________      _______________________
Researcher's Signature            Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.
Appendix F: Interview Guide

1. Could you tell me how long you have worked in this organization and your work experience with children and youth?

2. How would you describe the youth that you work with? What brings them to the residential program at Ranch Ehrlo?

3. How do you work/intervene with the youth when they have experienced issues related to trauma?

   Can prompt with:
   a. Abandonment;
   b. Betrayal;
   c. Physical assaults;
   d. Sexual assaults;
   e. Emotional abuse;
   f. Exposure to violence;
   g. Repeated changes in primary caregiver/s (multiple placements)/repeated separation from the primary caregiver;
   h. death or other losses of the significant other such as divorce

4. How do the youth that you work with present clinically?

   Can prompt with: Affect states, bodily functions, preoccupation with threat, risk-taking or thrill-seeking, self-soothing, self-harm, negative sense of self, distrust/defiance, reactive physical or verbal aggression, inappropriate attempts to get intimate contact, emphatic arousal)

5. Could you describe how the youth present in the following areas?
   a. Educational
   b. Familial
   c. Peer group
   d. Legal
   e. Health
   f. Vocational/employment

6. Tell me about your work with the families of the youth.

7. What are the strengths that the youth have?

   Of those, which strengths facilitate treatment/recovery from trauma?

8. How does Ranch Ehrlo, and the residential program in particular work with youth that have complex trauma experiences?
If necessary, explain complex trauma as: exposure to multiple and/or prolonged developmentally adverse events, such as physical, emotional, and educational neglect and child maltreatment beginning in early childhood (van der Kolk, 2005. Developmental trauma disorder: Towards a rational diagnosis for children with complex trauma histories.)

9. What type of challenges do you face in relation to working with youth who have experiences complex trauma?

10. What are your worries about the youth with cases of complex trauma?

11. Could you tell me about success stories on the treatment journey of youth with complex trauma experiences?