

CHAPTER SIX

WHEN LOSS GETS LOST: USING THE SELF MODEL TO WORK WITH LOSS IN RESIDENTIAL CARE

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Introduction

Residential care is rooted in loss. Children who are identified by their families, school districts, state agencies, or courts as being unable to function in their homes and communities due to behavioral and mental health issues are referred to residential care for treatment. Children in residential care live in a congregate setting with other children, and are cared for by staff, receive psychiatric treatment, and reside in a therapeutic environment in order to address the issues that keep them from functioning in a home setting. Often these children have visitation with their families on weekends and attend schools affiliated with the treatment centers rather than attend in their home school districts. The mere fact that children in residential care are separated from their families of origin to live with other children and unfamiliar caregivers suggest that loss is an inherent part of residential care. Many residential treatment settings have evolved from orphanages or similar institutions created to care for children who had lost parents, families and communities. Although over time residential treatment has moved to a more clinical focus, its heritage is deeply rooted in themes of loss that continue to be a powerful force in the experience of the children who are treated in these settings.

In addition to the separation from their families, children who are placed in residential care are particularly vulnerable to issues of loss, since many carry a history of abuse or neglect which precipitated their placement. For others, some discrete event or trauma may have been a precipitant to their placement in residential care. Trauma always results in some kind of loss, whether concrete

or less tangible. All children who live in residential settings have lost the sense of normalcy of living in a familiar place. Others experience a loss of safety, loss of family members, loss of innocence and loss of security. For families who are separated when a child is placed in residential care, even for those who place children voluntarily, there may be a loss of control, loss of identity, or loss of cultural traditions.

Despite the multitude of losses that are entrenched in residential treatment, we find that loss is often overlooked in the day-to-day work of caring for traumatized children. There are a number of reasons for this oversight. Often it is difficult to know where to focus on any given day in a residential treatment setting. There are issues such as physical and social safety, and other issues like family reunification, foster care placement and long term institutional or hospital care that conspire to divert the attention away from addressing loss issues with our children. The result of these daily demands raises key questions: How can residential treatment centers balance the competing priorities of our children's safety, their expressions of pain, frustration and loss of hope? How may they effectively manage staff's safety? Also, how might these institutions manage the projected pain of socially injured children, manage organizational expectations, and also address financial responsibilities? Specific demands that stem from issues relating to health care, education, recreation, creativity, psychotherapy, family therapy, medication, family reunification, and foster care placement create a complex web of potential problems that is further complicated by issues relating to placement for those without parents or foster families. Mandates about documentation, even the participation in court proceedings, contribute to a perplexing litany of issues. Obviously, within this catalog of competing priorities, it is easy to see how addressing grief and loss readily may be overlooked.

Another reason that this prevalent grief and loss in residential treatment may go overlooked is lack of recognition. Typically, caregivers focus on concrete or tangible losses, but may not identify secondary or intangible losses. What are tangible and intangible losses? Often children in residential care may have suffered the loss of family members through incarceration or endured the loss of their homes, their relationships with friends and extended family, as well as the familiarity of school or community. Some may have endured the death of a loved one, perhaps a beloved sibling or parent. These are tangible losses. There is some tangible or at least identifiable aspect of life that is lost. Intangible losses—referred to also as secondary losses are identified as those often felt by marginalized populations, those people with little power in the larger system. These intangible losses, somehow as invisible and overlooked as wallpaper, often may be more insidious and damaging. For example, many residential care prospects are children of color who come from impoverished

communities; they and their families often cope with painful issues stemming from their experiences of subjugation. These social wounds—the loss of one’s voice, the loss of a sense of efficacy, loss of a sense of heritage and history, a constant push from society to compromise oneself to those who are privileged—often engender extraordinary rage¹. It is often this very rage that drives the behaviors which bring many children to residential care.

This rage also may fuel the behaviors of family members, many of whom are also people of color who have experienced trauma in addition to the subjugation and degradation of racism. A significant strain, and one often unspoken in these decisions to remove children from their homes, is that of institutional racism. Many of the children who are taken out of their communities and placed in residential care are children of color. Frequently, they are placed in agencies where the decision-makers and power-brokers are white. The implicit message that families and communities of color are incapable of caring for their own children underscores the damaging loss of family and community.

Many of the behaviors we see in the acting out children of residential treatment may be directly related to loss. Investigators have written about the cycle of violence among adolescents and the failure of acknowledging aggressive acting out as an expression of the dehumanization of loss. Losses that are “unacknowledged, not mourned and unhealed” are the fuel for the phenomena of rage. Unless the source of rage is addressed, it will continue to fuel destructive behavior. Describing this palpable rage, the authors suggest, “It is a natural and inevitable response to experiences of pain and injustice”². When these losses affect children of color, the devaluation of loss also seems to simultaneously underscore the devaluation of people of color. Similarly, the same can also be said of LGBT children who are devalued simply because their sexual orientation is different from that of the mainstream population.

As one author observes, many of our youth seem perpetually angry and when hurt show anger more than hurt. “*Suppressed grief often turns into depression, anxiety or addiction. Benumbed fear can easily lead to irrational prejudice, toxic rage, and acts of violence.*”³ This anger is often “*a shield of one’s vulnerability*”⁴. These researchers suggest that society unfortunately will continue to experience problems with safety and emotion management in children in residential care until these issues of loss are effectively acknowledged and treated.

[1] Hardy, *African American Experience and the Healing of Relationships in Family Therapy*; Hardy and Laszloffy *Teens Who Hurt*.

[2] Hardy and Laszloffy, *Teens Who Hurt*, p.29.

[3] Greenspan, *Healing through the Dark Emotions*, p.xii

[4] *Ibid*, xiii

Rage, together with a build-up of intangible losses, may also affect organizations themselves, those facilities dedicated to helping these children. In many ways, residential treatment is viewed as a step-child in the field of mental health. Residential settings are often seen as holding cells for the most disturbed and hopeless cases, the last stop on the train before jail. Staff members who work in residential care are often poorly paid and frequently seen as babysitters rather than valid and meaningful treatment providers. Therefore, as a marginalized field, residential care remains vulnerable to the effects of these same secondary losses. The destructive cycle of trauma, coupled with issues of subjugation, seems to cut across the client, family and the organization itself, ironically the very system developed to help these children and their families. These layers of secondary loss are rarely recognized and less likely to be addressed.

Additionally, there is this daunting reality: Grief work is painful for *both* the child and the staff. Loss is so painful for our children to face; it is equally disheartening for staff members to witness. Yet, unresolved loss leads to a cycle of reenactment of past adversities in current relationships. Clients engage in a dynamic with staff or others in a way that recreates the roles of persecutor, rescuer and victim. One group of experienced clinicians refer to these reenactments as the expression of unresolved grief, of “never having to say good-by.”⁵ If clients are unable to make a connection between their symptoms and their previous experiences, then they are doomed to repeat them. Sadly, people are unable to move towards a better, more meaningful future. Likewise, it has been observed that “Helpers don’t want to talk about this information, so that they will frequently change the subject or minimize the pain.”⁶

While the desire to minimize pain is a natural human tendency, this desire can undermine treatment. This unintended effect is unfortunately fairly evident in a multitude of examples in residential care. It is often a point of pride for an agency to know that it is giving the children both a better experience and better life than they may have had at home. It is also a point of pride for programs to be clinically astute and diagnostically savvy. Yet, it is frequently these very desires to do good work which can sometimes undermine the recognition and treatment of loss and grief with children.

[5] Bloom, Foderaro, and Ryan, *S.E.L.F.: A Trauma-Informed, Psychoeducational Curriculum*

[6] *Ibid*

This chapter explores issues of loss in residential care through case examples of children, families and a residential treatment center as a system. It focuses on the use of the Sanctuary Model, in particular the use of SELF as an effective and meaningful tool for addressing trauma and loss for children, families and entire systems.

The Sanctuary Model

The Sanctuary Model®, created by Dr. Sandra Bloom and her colleagues, represents a trauma-informed method for creating or changing an organizational culture in order to more effectively provide a cohesive context within which healing from psychological and social traumatic experience can be addressed. It is a whole system approach designed to facilitate the development of structures, processes, and behaviors on the part of staff, children and the community-as-a-whole that can counteract the biological, affective, cognitive, social, and existential wounds suffered by the children in care.

The Sanctuary Model was originally developed in a short-term, acute inpatient psychiatric setting for adults who were traumatized as children. The Model has since been adapted by residential treatment settings for children, domestic violence shelters, group homes, outpatient settings, substance abuse programs, parenting support programs and has been used in other settings as a method of organizational change.

The aims of the Sanctuary Model are to guide an organization in the development of a culture with seven dominant characteristics, all of which serve goals related a sound treatment environment:

Culture of Nonviolence – building and modeling safety skills and a commitment to higher goals

Culture of Emotional Intelligence – teaching and modeling affect management skills

Culture of Inquiry & Social Learning – building and modeling cognitive skills

Culture of Shared Governance – creating and modeling civic skills of self-control, self-discipline, and administration of healthy authority

Culture of Open Communication – overcoming barriers to healthy communication, reduce acting-out, enhancing self-protective and self-correcting skills, teaching healthy boundaries

Culture of Social Responsibility – rebuilding social connection skills, establish healthy attachment relationships

Culture of Growth and Change – restoring hope, meaning, purpose

The SELF Model

SELF is an acronym which stands for Safety, Emotion management, Loss and Future. Developed by Dr. Sandra Bloom and colleagues as part of the Sanctuary Model⁷, the SELF Model (referred to in early writings by Dr. Bloom and her team as SAGE – Safety, Affect management, Grief, Emancipation – rather than SELF)

is not a stage oriented treatment model, but rather a nonlinear method for addressing in simple words, very complex challenges. The four concepts of the model include: Safety, Emotions, Loss, and Future, representing the four fundamental domains of disruption that can occur in a person's life and within these four domains, any problem can be categorized.⁸

When we refer to the acronym as a model, we are referring to its use as a framework for organizing conversations, treatment planning, and treatment itself. Issues of safety, for example, include physical, psychological, social and moral safety. In simplest terms, physical safety means that our bodies are safe from harm; psychological safety means that we are safe with ourselves (we have self-esteem, self-protection, self-discipline, etc.). Social safety means being safe with others (having social responsibility, healthy attachments, responsible authority), and moral safety means being consistent with one's values, beliefs and conscience⁹. The second letter in the acronym stands for emotion management. Work in this area focuses on recognizing feelings and their connection to behaviors as well as managing feelings well enough that one can control behaviors rather than act feelings out in maladaptive ways. The third piece of the SELF model is loss. Work in this area involves recognizing, honoring and moving past resistance to change. It requires letting go of the past while incorporating important experiences into one's identity. The final component of the SELF model is future, finding new motivations, risking new experiences and relationships and choices and moving out of maladaptive patterns of behavior.

Because the experiences, skills, challenges and strengths that any client, family, staff person or organization presents may vary, the goals and tasks involved in the SELF process will look different for different people or groups. The model is dynamic and adaptable, providing a frame for the work to be done in healing. The model also serves as a safeguard against overlooking

^[7] Bloom, *Creating Sanctuary: Toward the Evolution of Sane Societies*

^[8] Bloom, Foderaro, and Ryan, *S.E.L.F.: A Trauma-Informed Psychoeducational Curriculum*

^[9] Bloom, *Creating Sanctuary: Toward the Evolution of Sane Societies*

loss. As loss is a critical component of the model, it becomes a focus of discussion and treatment.

Loss for Children in Residential Care

What society does to its children, so its children will do to society
– Cicero

We often find that children and families can be extremely resistant to dealing with loss. Well-intentioned staff members can be just as avoidant. At times, the wish to avoid pain, the struggle of competing priorities and the inability to recognize bereavement as an integral part of trauma treatment can result in this phenomenon of loss getting lost. This was strikingly clear in a case of a child who witnessed the murder/suicide of her parents.

Grace

Grace was an eleven year old girl who came into residential care with pigtails and large round glasses. Her shy demeanor and simple smile belied the complexity of her circumstances. During the course of her stay, Grace was subjected to custody battles among family members who were reeling from the murder/suicide of Grace's parents, court proceedings, media attention, legal issues regarding visitation, and the involvement of multiple service agencies. Compounding this complexity was Grace's confusing presentation of symptoms: psychotic episodes, suicidality, provocative behaviors, extreme neediness, dissociation, gaps in memory, and extremely poor social interactions. The team immediately recognized the symptoms as post-traumatic stress disorder and focused on helping to stabilize her. Unfortunately, with all of these clinical issues to address, including her medications to administer and her safety to monitor, the staff had little opportunity to begin addressing this child's profound sense of loss. The staff was largely focused on keeping her safe. Staff members were unsure that the traumatized child could tolerate talking about her loss.

Grace was placed in residential care within a week of her parents' deaths, after a state agency took custody of her. Grace made some gains in her treatment, but was placed in the home of a relative several months after placement in what the treatment team felt was a premature attempt to provide normalcy and restore order to her life. Although she had been in care for several months, she had not even begun to participate in a bereavement group, as the treatment had focused exclusively on treating overt psychiatric symptoms. The family member she was placed with felt that the best way to help this child cope with her experience was to give her a new identity. She moved the child to another state and advised the new school that Grace had lost her parents in a car accident. The desire of this family member to protect Grace from further pain

instead stifled Grace's ability to process her experiences and deal with her grief. Her new identity provided an opportunity to start anew, but provided her with an altered reality, risking the possibility of invalidating her trauma and grief experience. There are numerous examples in residential care of the ease with which caring adults manage loss issues for children in ways that can unintentionally disrupt appropriate grieving. Frequently the issue of loss is placed at the bottom of the child's emotional priority lists or completely overlooked.

Acknowledging Loss

We have seen in residential settings the staff's vulnerability to overlook or avoid issues of loss. But we have also seen the unexpected ability of very troubled children to make progress around issues of loss. This was clearly demonstrated in one team's work with a young man who had been in residential care for five years. He was an extremely aggressive child who had hurt other children on several occasions. The staff used the SELF model in their thinking and treatment planning with him.

Gregory was a slight boy whose small size encased a well of emotion and anger. He had been in residential treatment since the age of six, having been removed from his home with his siblings after the children disclosed sexual abuse by a relative in the home. His parents were incarcerated, and although he had very limited contact with his other relatives, he had developed a strong sense of family and connection with his sisters. The team knew of his precipitous situation: one sister had been discharged to family only to move into a homeless shelter, and his other sister was at risk of leaving residential care for a more restrictive environment due to her declining functioning and dangerous behavior toward others. The staff members were also aware of Gregory's history of sexual abuse, physical abuse and extreme neglect. Despite their awareness of these losses, the staff found their attempts to talk with the child thwarted; he overtly avoided and rejected their attempts. Additionally, his use of negative behavior to avoid talking about these issues confounded effective treatment. Despite their efforts, the staff members continued to struggle with how best to address this child's loss issues, which they believed were at the core of his behavioral issues.

Most interventions focused on how to help Gregory stay safe, how to help him manage his emotions in order to keep the other children and staff around him safe, and how to work toward being able to live in a family setting in the future. Although they were not feeling particularly effective in their repeated attempts, the staff's use of the language of SELF, coupled with their

creation of an emotionally intelligent environment and their awareness and openness about their own feelings, helped initiate a healthier treatment program. This environment laid the ground work for Gregory to begin to address his own grief work at his own pace. At one point, one of the direct care workers in the cottage who worked with Gregory daily lost her grandmother to an illness. She came in to work the next day, and Gregory immediately approached her. Neither she, nor any of the other staff, had shared her loss with the children, but the worker reported feeling that Gregory “just seemed to know” that something was wrong. The worker described her typical interactions with Gregory as fairly volatile, noting that she had come to expect aggression or insults from him most of the time. She was surprised when he came up to her and asked what was wrong. She shared with him that her grandmother had died, and he responded with appropriate apologies for her loss. His ability to relate to her in a compassionate way after her loss set her on a path of thinking about Gregory and the other children in a different way. The worker used her own experience of grief as a spring board for thinking about the losses of some of the children with whom she worked. She approached a teacher who worked with many of the boys in her residential unit, and suggested that they begin a loss group together. Knowing of the multiple losses that this one boy had experienced, she asked him to join the group. She and the teacher were not surprised by his refusal to participate and his denial of any losses in his life.

Several months later, this Gregory’s grandmother, the woman from whom he was removed, and with whom he shared a very ambivalent relationship, died. He asked the same worker who had lost her grandmother to accompany him to the funeral. She reported to her colleagues when she returned with him that it had been an extremely emotional experience for him – and for her. His mother had been in attendance, but had not recognized him, as she had not seen him in many years. He had clung to this worker for most of the day, seeming very conflicted about connecting with the relatives who had abandoned him. That evening, the child approached the staff member who had accompanied him to the funeral. “What am I supposed to do now? I don’t know how to go on. How did you do it?” he asked, referring to her coping with the recent loss of a grandparent. She told him that she was still doing it. She talked about grief as a process that she deals with every day. They began to talk about their shared losses and their experiences of losing a grandparent. The child was able to begin talking about some of his other experiences, framing them as losses. The staff and child were able to grieve together in a contained and safe way, allowing the child not only to experience being cared for, but also the experience of caring for someone in his community without being parentified or exploited, another common experience for him. This interchange prompted the child to participate in the loss group.

Creating a Context for Loss – “L” Groups

With a new awareness of the importance of addressing loss, groups were piloted in one classroom at a special education school on the campus of a residential treatment center to specifically address loss. As a way of reinforcing the groups as consistent with the SELF model, the staff and children decided to call them “L” groups. When the staff first conducted the initial “L” Group, all were anxious about “upsetting” the students. The hesitation that the adults had about how the students might respond was countered by the students’ capacity for tolerating their own emotions and each other’s. Even though one student was very sad when talking about his loss, he did not act out his anger. The student spoke of losing his good relationship with his mother during a disagreement. He was able to share his observation of his own process, noting a transition in his behavior: he did not trash his room as he usually did when he was upset. Another student was looking sad and was asked about his loss. He said he had lost something very important, but he did not want to talk about it. The group expressed compassion and acknowledged his loss as being important even though it was not shared with them. By the time the group went around the circle, the student who did not want to talk earlier decided to tell the group that his puppy had died last night. It was with some trepidation that group members asked him if there was a benefit to talking about his loss. He said that he would have taken his anger out on his classmates and teachers if he had not talked about it in the group. He then got help from the group in developing a safety plan for the day. Several group members told him they would respect his feelings and offered to check in with him during the day. This was extraordinary for this student who is characteristically withdrawn and tends towards acting out behaviors and for his peers who are much quicker to distance themselves from the pain of others by lashing out or teasing than by showing compassion.

It is the desire to strike a balance in treating these children that demonstrates how tenuous discussing loss may be. The fear of upsetting the children, of making their already painful lives worse often drives our staff members to avoid directly dealing with issues of loss. For example, when the loss itself is the reason for admission to a residential program, the staff, child and family may be forced to deal directly with that loss. Yet, the issue of family secrets that surround losses may compound the difficulty that some children experience when deciding whether or not to disclose information relating to loss. There are instances when children fear that they will further damage a relationship with a parent by discussing a loss or when they feel that disclosure may cause a family member to be in trouble with the law. Grieving may be inextricably linked with the risk of further loss and, thus, may even be more

complicated than initially diagnosed. Such was the case for one young girl, Lily, and her treatment team.

Lily

Lily's sadness was palpable to the staff when they met her. She greeted people with her story, introducing herself with the information that her brother had died, and the police had taken her away from her mother. When she came to residential care, Lily was at first quite open about sharing her story, showing pictures of her sibling and talking about her experience of the funeral. At some point, however, this openness and willingness to talk diminished drastically. She was more and more resistant to talking about her memories relating to the death. This was a clear departure from her presentation and from earlier sessions with the therapist in which Lily had initiated conversations and described in detail her recollections of the event. The team noticed that somewhere in the course of her treatment, this child began to feel unsafe sharing this heartbreaking loss.

There were a number of factors that were likely contributors to Lily's closing down, many of which seemed tied to her belief that sharing her loss would risk greater loss. Around this time, her mother was allowed contact with her, when earlier there had been a court order denying contact of any kind. Lily seemed aware of her mother's fear that speaking of the death, the investigation, a report of abuse, Lily's removal, in a sense "airing the family's laundry," might have severe consequences. Perhaps the information would be used against the mother in court. Perhaps Lily would not be allowed to see her mother again if she disclosed family problems.

The desire to protect their family became a barrier to grief work. Lily's mother had once stated: "We'll only be able to work on our relationship after she is home. I don't trust that they'll let her come home if she starts talking about what's happened." Despite their initial mistrust, Lily and her mother began to have positive visits and began to work on safety and emotion management in family sessions. The team felt that they should be allowed unsupervised visits, and a new visitation arrangement it was granted. Several months later, after ongoing visitation and a beginning focus on the loss that the family had faced due to the death of her brother and Lily's removal, Lily's mother appeared before a criminal court judge regarding charges of abusing Lily. There had been some miscommunication among lawyers, family court, criminal court and treatment providers. After months of visitation and family therapy, the criminal court determined that an order of protection was still in effect, and that Lily's mother's contact with her daughter was a serious legal transgression. Further, there was to be no additional contact with her daughter until the next court date. This drastic turn of events seemed to confirm for both Lily and her mother that the system could not be trusted. Although the reality

was more complicated, Lily's experience seemed to suggest that when she began to talk about her loss, she was no longer allowed to see her mother.

Other factors also were likely contributors to her refusal to talk about her losses. Few things are more disturbing than the death of a baby, and the staff who worked with Lily acknowledged their discomfort about the baby's death. Over time, most conversations, therefore, addressed Lily's presentation and behavioral issues. It seemed a far easier matter to focus on her demeanor. Treatment more readily addressed Lily's behavior which was presumed to be manipulative and attention-seeking. Although everyone on the team knew the significant losses— death of her sibling, removal from her home, and abrupt severing of maternal contact — these topics were only lightly recounted and inevitably quickly dismissed in conversations. Instead, the team stressed developing behavior plans and arrangements for Lily's discharge to a foster home.

At this juncture, the importance of the SELF framework surfaced. Lily's team met for a quarterly treatment planning conference, and in the course of talking about her progress in the areas of Safety, Emotion management, Loss and Future, they recognized that they had barely addressed the severe consequences of Lily's personal loss. Even though death is often the most obvious form of troubling loss, in Lily's case, her sibling's death was often overshadowed by other issues in the course of her treatment. The team then decided that Lily would be a good candidate for a trauma-specific intervention. With the help, support and agreement of the treatment team, the clinician began using trauma focused cognitive behavioral therapy with Lily. This treatment protocol deploys a gradual exposure to the traumatic event, often through narrative devices¹⁰. As the work progressed, Lily continued to demonstrate significant resistance to sharing details. Lily had already made the connection that disclosure was equated with punishment. Her experience suggested that her mother's removal from contact was the price of disclosing physical abuse. In sum, talking through loss seemed to trigger a court order denying contact with her mother.

Lily's cognitive behavioral therapy program, however, did offer a process which held a special appeal for the child. This particular trauma-focused cognitive behavioral therapy protocol involves sharing the narrative with an adult. Lily had built a relationship with her previous foster family, and wanted to share her story with her foster mother. She also wanted to share her narrative with the staff of her cottage. Her therapist arranged for sessions in which Lily could read her narrative with her foster parent, and as the protocol suggests, help the foster parent respond to Lily in an affirming and supportive way. The staff also heard her narrative, with Lily's permission, and was immediately sensitized to her

^[10]Cohen et al, *Childhood traumatic grief*.

experience. The exposure to Lily's narrative and therefore to her loss experience helped change the staff's perceptions of Lily's behavior, framing many of her past actions as reenactments of her painful home situation. They began to recognize that her troubling performance was actually a series of unsuccessful coping responses, not manipulative and attention-seeking actions, as they previously thought. Lily, herself also seemed to change. Her initial resistance began to dissipate and she was able to talk about her future as well as express her ambivalence about living with a foster family and returning home. When Lily began to acknowledge her losses, do some grieving work, and share her experience with adults who could tolerate hearing her pain and be supportive, she was more able to stay safe, manage her emotions and work toward goals related to imagining her future.

Changing Expectations – Facing Loss

Part of the unspoken culture of residential organizations is the inherent and very strong desire to protect the children in care. In part, this may be due to many residential treatment centers' heritage as former orphanages. As agencies, it is common for staff to go to great lengths to ensure that children are well cared for, and that they can have access to trips or material things that they may not have had previously. Staff seek to insulate the children from painful experiences. This often takes the form of overt and perhaps an unconscious response by the staff to collude with children to avoid talking about the children's painful pasts.

With the introduction of the Sanctuary Model, and specifically SELF, in one residential program, staff have been able to create the opportunity to talk openly with the children about loss and grieving. In fact, it has become expected of the staff to do so. Any potential emotional minefield instead becomes an opportunity; crisis can be diffused when the children begin to incorporate the language of SELF into their daily programs. What was once the exclusive domain of therapists and confined to 45 minute sessions once or twice per week has become part of the culture of the community. Treatment has now been imbedded in the milieu of the residences and school in community meetings, therapy groups as well as the daily activities of meal times, recreation and night time transitions. Staff also have found that as part of a treatment community, they can use themselves as models for how to manage emotions regarding losses that are appropriate to share with the larger community. Allowing children to give voice to their losses, having the expectation that they can in fact heal from loss, and expecting that staff members will do the same, are part of creating a functional therapeutic milieu.

Loss for Families with Children in Residential Care

Part of my frustration with our field is that we seem so determined to locate human suffering narrowly while ignoring broader ecological perspectives. In family therapy we pride ourselves on having a systemic understanding of problems that we need to look not just at the individual, but at the whole family. But in some ways this is still very narrow, because the family exists in a broader socio-cultural context ¹¹. (Hardy, 2001)

Like the children who come into residential care with unresolved grief, many parents suffer from the affects of loss. We often find that parents feel guarded or mistrusting of the systems that are designed to help them reunite with their children. The children who come to residential care are often the youngest in a long line of intergenerational adversity. Whether families have suffered tangible or intangible losses, we often see the effects of these experiences in their behaviors. Just as we overlook loss issues in treatment with children, we are likely to overlook issues of loss for parents and families. In some instances, it seems that intergenerational loss begins to define a family system and traps it in chronic reenactments, as it did for a mother named Karen and her children.

Karen

Karen was pregnant with her fourth child when her daughter came into residential care. Fearful, heartbroken and admittedly mistrusting, Karen described having lost one child to her husband's family in a custody dispute, having lost one child to Sudden Infant Death Syndrome and "having lost the other to the foster care system." Karen talked about the unresolved losses that were likely contributors to her substance use. She also shared her belief that her own history of loss played a role in her children's experiences. She shared various losses endured in her childhood and early adulthood. For example, her mother had been an alcoholic; their relationship had been very conflicted. Further her pain was compounded through other serious losses. Karen had been raped several times, she lost friends to suicide, lost her grandparents who were her primary caregivers, and eventually lost her childhood home in a legal battle with her brothers. In sum, she had lost her sense of self. She became agoraphobic, explaining that she often felt buried alive by her fear. She made a clear connection between her own adverse experiences, her reactions and the experiences that her children were having. Some of her children's negative experiences were directly related to her own reenactments of her trauma history. Karen shared her wish that her own children would not suffer as she had. She also realized that her unresolved losses had played an undermining role in her children's lives.

^[11] Hardy, *African American Experience*

Karen's unusual insight allowed her to acknowledge the effects of her unresolved grief and determine to work through her losses. She recognized that the death of her baby and the removal of her daughter were the most significant blows. But Karen also identified the ripple effect of those losses. She talked about feeling that her friends felt awkward around her, often seeming to be unsure of how to speak with her, afraid that any mention of her children would upset her too much. Karen also spoke about the loss of her apartment. Her daughter's reunification with her was based on her having a suitable home. For this reason, Karen would need to find a larger place to live. Although she wanted to comply with the court and move to a new home in order to have her daughter returned, she felt conflicted. She was very reluctant to leave her apartment because it was where her son had died. She said,

I know that some people think it's weird, but I feel safer there. I feel close to him there. There is a little boy who lives upstairs who was born a few months before my son was. I look at him and think about what my son might look like. I look for signs from God like that.

Although Karen struggled with the significant losses in her life, she was like the children who are treated in residential care in her resilience. She spoke about her choice to have an open casket at her son's wake, despite the negative responses she experienced from relatives about her decision. She recalled, "I didn't want people to see a closed box. To me, it just seemed more personal. I had to see him one more time to say goodbye." Karen talked about having made the same decision about her mother's funeral, needing the visual experience of closure. She remarked that she lights a candle at each holiday in order to remember her son and puts up an empty stocking for him at Christmas. In the course of treatment for her Karen's child, it became clear that grieving and healing from losses would be the work of the entire family, not just the identified client – the child. In this case, and likely in many cases, it is unresolved grief that explains why family systems frequently repeat cycles of violence and reenact trauma.

Karen's sobriety has played a significant role in her work to regain custody of her daughter. Her participation in substance abuse treatment has helped her to grieve in her own way. She talked about her hopes for the future for her family. "I just hope my kids can be happy, that we can come together as a family and be happy. I've been sober for 16 months and I expect my daughter to come home in a few months."

Secondary Losses for Families

Just as the children in residential care face intangible losses related to being part of a marginalized group, families with children in residential care face a multitude of secondary losses. Often, families are allowed limited contact with their children in residential settings in the form of weekly or biweekly visits. When children are allowed weekend or overnight visits with their families, they may maintain some contact with their communities. But they live the rest of the week in another place, going to a different school and remaining separate from their own communities. This separation contributes to a significant secondary loss, one which may be exacerbated when the privilege of visiting one's family is tied to the child's behavior. In residential care, it is common practice to keep children from home visits if they misbehave. This is often done in the service of safety, using the logic that if the child cannot manage his/her behavior in the residence, he/she certainly cannot do so in a home setting in the community. What may be missing from the equation is that the separation from one's family actually may be contributing to the acting out behavior. In this way contact with one's family or community is presented as either a reward or something to be taken away as a punishment. Despite the good intentions of the residential staff to keep the child safe, the child and family may view this protective intervention as punitive.

The SELF model can be effective in managing secondary loss in that it allows a context for discussing all sides of a decision, and the dialogue promotes the involvement of the child. In most residential treatment settings, the conversation is likely to focus exclusively on safety and end there. In using the SELF Model, the context for discussion includes the emotions and management of these emotions for the child, the staff and the family. Conversations organized around the SELF components also acknowledge the loss created by the separation from family and community and offer the possibility that further work on safety and emotion management might lead to a different outcome in the future.

The marginalization of families with children in residential care can manifest in other ways. A family's sense of itself as a self-determining entity may be compromised by residential care. Most families have their own definition of who they are; they may function as autocratic decision-making bodies for themselves. Independently they may choose to accept or disregard advice or criticism from outsiders. When children enter residential care, the sense of family sovereignty and the boundary between who is in the family and who is outside of the family is often breached. This schism may be further exaggerated by the rules of the child welfare system, especially for those families whose children are removed by the state and placed in residential care.

The break also may be exacerbated by issues of institutional racism and poverty, the secondary losses that Hardy describes. The control over the care of their child is left up to the state, and families are forced to submit to rules and regulations that may seem unfair and infuriating. Because the need to protect children is paramount, and the results of failing to do so can be deadly, social services, the courts, and agencies that contract with them to provide residential treatment must be vigilant in protecting children. These systems, however, often exacerbate the experience of marginalization for families. The family court system, with its participant arrangement (the parent as respondent, the state or county child welfare agency and a legal advocate for the child) often inadvertently sets up an adversarial relationship between parents and the agencies that are trying to help them and their children. It is this very attempt by our legal system to intervene on behalf of children that disrupts the powerbase of many families. This adversarial basis engenders an inherent lack of trust between families and agencies and places agencies in the precarious situation of determining when to allow contact and how trustworthy parents may be with their own children.

Residential settings often describe themselves as being family-centered; they make attempts to include families in various decision-making steps in their treatment programs. Although this may be their intention, residential settings are sometimes hindered by court or state mandates in meeting this goal. Frequently residential resources or manpower also are hindrances. It is common practice for children who have been removed from their families to have only supervised contact with their families. During these supervised visits, an agency worker must sit and observe the family, watching and making note of anything that might be deemed inappropriate. Parents and families in this situation have complained about feeling watched and judged by this process. This, too, represents a loss as the inherent boundaries of the family have been breeched by the addition of a watchful third party.

The limitations on amount and length of contact are also contributors to a sense of marginalization for families. With limited resources, many residential settings find it difficult to pull staff members away from their other work in order to supervise a family visit for more than an hour. With the number of children in these programs and the number of times families wished to come per week, some residential settings have found themselves struggling with staffing resources and space to provide visit supervision. Many families and children have reported feeling frustrated by the limited contact and the parameters set for them by social services, the court and residential agencies. The secondary loss of family self-determination is compounded by other restrictive variables: visitation hours, number of visitors, the need to clear family members with social services or the court before contact is allowed.

There may be restrictions, too, on gifts as well as the number and length of phone calls. In light of these restrictions, many parents report a sense that they are being judged for their parenting skills, viewed as incompetent or criminal. In some cases, explosive or rageful behavior on the part of a parent in response to staff limit-setting can be traced to these feelings of marginalization and intangible loss which are created by the systems that serve children. Without understanding the context of this anger and acting out by parents in the context of secondary loss, many of these interactions become reenactments of the persecutor, victim, rescuer dynamic. The traumatic experiences are reenacted between the family and the service providers.

Again, because of the unsafe experiences many residential children have had with their families, the restrictive interventions are done in the name of safety. There are many parents who need the guidance of a trained staff person to help them interact appropriately with their children or to help them manage their children's behavior during a visit. However, a parent's perception of this is marginalizing is heightened when these interventions are viewed as punitive rather than as helpful. Fortunately, working through the components of SELF with parents along with their children can be a way to acknowledge the loss that occurs when the nucleus of the family is compromised while emphasizing the need to manage emotions around the loss. Working toward achieving physical, social, psychological and moral safety during visits and phone calls can ensure that family self-determination is restored in the future.

Resiliency

Families are incredibly resilient, and in fact most of the workers in the child welfare system are smart, well-intentioned and kind. When these workers are able to recognize the conflicts that the child welfare system creates and can think about the long term safety and needs of the children—rather than the short-sighted fixes that some policies mandate—they are able to help children and families overcome significant loss, while working toward reunification. The adoption of the SELF framework by a social services worker and residential team in the case of Leah and Chris was one such example.

Leah and Chris

A young sibling pair, Leah and Chris, were physical opposites of each other. Leah was small and stout next to her brother's lanky frame. Their physical differences highlighted their differences in personality, Leah an outgoing chatterbox and Chris a reserved boy. The children had been living with a pre-adoptive foster family for several years and had been freed for adoption. Their adoption had not been finalized, but there were a number of other children in the

home who had been successfully adopted from foster care. Leah and Chris had come to residential care after being removed from their pre-adoptive parents when it was learned by local authorities that the oldest of the adopted children had been downloading pornography from the internet and taking provocative photos of his teenage sisters. This child, a teenager himself, was removed from the home and referred for treatment. Because the other children in the home had already been adopted, they were allowed to remain in the care of the parents, but the youngest two were removed from the home. Because their adoption had not been finalized, the county workers had to reconsider whether this home was suitable as a permanent place for Leah and Chris. The parent's ability to supervise the children appropriately and care for these two siblings was in question.

The state had the best interest of these children in mind, but also faced the dilemma of managing the legal issues that the situation presented. From one perspective, it appeared that the parents had been negligent in supervising their teenage children; after all, they were unaware that their oldest son might be a sexual predator. From another perspective, it seemed that these parents, and more significantly, that these two children, were being punished for the sexual curiosity of a teenage boy. The caseworker was able to appreciate both perspectives, and worked with the family and the treatment team at the residential treatment center to determine the best course of action. Had she only looked at the facts of the case, the worker quite possibly may have begun looking for an alternative placement for Leah and Chris. Safety outweighs almost every other consideration in determining placement, but the treatment team and the social services worker were able to explore multiple definition of safety in making plans for this family.

The treatment team, which included the parents and the social worker from social services, was able to look at physical, psychological, social and moral safety as factors in their decision. Physical safety was the easiest for all parties to understand and work around. Physical safety meant making sure that the children would not be exposed to a sexual perpetrator or be at risk for sexual or physical abuse. It meant that their corporeal needs would be met through appropriate housing and availability of resources. Psychological safety involved creating an environment that allowed appropriate expression of emotions, tolerance for strong emotion coupled with the ability to manage strong emotion without hurting oneself or others. A psychologically safe environment is free from neglect, humiliation, blaming, shaming and fear of reprisal. Social safety represents the ability to feel secure within one's social group or family, and that one will not be ostracized or rejected for being oneself. A socially safe environment is free from abusive attachment, isolation, abusive uses of power, weak boundaries or tolerance for inappropriate behaviors. Moral safety allows

for people to feel safe to make ethical decisions and choices. A morally safe environment is free from dishonesty, injustice, discrimination and perpetration.

The team agreed that the decision to remove the children and disrupt the adoption process seemed to provide a certain level of physical safety for the children. The problem with the decision was that it had greatly interfered with the emotional, social and moral safety of the children and family system. The sibling pair had a very strong and secure bond with the parents and the other children in the home, therefore their sense of emotional connection and sense of family was disrupted by the removal. This was one in many betrayals and disruptions for them, including their abandonment by their birth parents and their subsequent disrupted placements in other foster homes. The decision also marked a departure from social safety since it took two children who had identified as full members of a family, and placed them in a system where they felt vulnerable and isolated. Their placement reinforced their belief that they were not real or true members of a family they had lived with for years. The decision also presented a lack of moral safety; it seemed to demonstrate to the children and family that it was acceptable to punish people because of the mistakes of others.

When the treatment team and social services worker were able to reframe the issue of safety to include all of the dimensions, the team decided to work toward returning the children to this home. The family was able to change the layout of the house so that the children would be more easily supervised to provide better physical safety. Most importantly, the family met together to talk about what had happened. These discussions opened the door to more healthy communications about boundaries for the younger children and sexuality for the older children, making significant progress in both psychological and social safety.

These conversations were also a way of creating a dialogue about the losses that the children had experienced in their lives. Discussions framed in the SELF components helped address past losses in order to create a future that would not recapitulate these losses. The team and family were able to better understand Leah and Chris' separations from previous families, their identity as children of color, traumas they had experienced prior to placement as well as the traumatic experience of being interviewed by the police, and learning of their siblings' involvement in inappropriate sexual activity. Their removal from their pre-adoptive family presented a potential trigger for some of the problematic behaviors they were presenting. To help restore the family's sense of self, the team encouraged them to talk about loss. This emphasis was more constructive than previous discussions focusing strictly on diagnosing the issues at hand. Together, the team, social service worker and family sought to repair

relationships rather than cause a painful emotional schism by removing the children permanently.

Losses for Residential Treatment Settings as Systems

The solidarity of a group provides the strongest protection against terror and despair, and the strongest antidote to traumatic experience.

—Judith Lewis Herman, *Trauma and Recovery*

Organizational systems face multiple significant losses all the time. There is the loss of residents and students as they graduate out of the residential system, return home or are placed with foster parents. There is the loss of students who cannot return to facilities because they require hospitalization or require a different level of placement. Tragically, there is the loss of former residents to suicide, prison or accidental death. Residential settings also face the loss of staff, those who leave to care for own families or for new positions. Job burnout in residential care is a significant source of loss. At times, the weight of all of these losses is overwhelming. It interfaces with an individual's

inability to bear the core triad of grief, fear and despair that (are) the source of much of our individual and collective emotional ills¹².

Just as families may suppress grief particularly when there are multiple losses, organizations also suffer from the effects grief suppression. Perhaps mental health professionals are especially avoidant because these losses are things that cannot be “fixed or cured”¹³. In the context of loss for families, McGoldrick and Boundy suggest that the lack of acknowledgement of loss has “immediate implications for that family's development over its life cycle and long term effects across generations”. The enduring after effect “is that failure to adequately mourn losses results in enduring maladaptive patterns”¹⁴.

Organizations, much like individuals and families, may demonstrate these maladaptive patterns in response to un-mourned loss, becoming immobilized, depressed, and expressing reenacting behaviors. As a result of this organizational immobilization, residential settings often settle for treating behavior rather than connecting behavior to its source. Workers in residential care risk becoming detached, focusing on order rather than repairing attachment by being attuned to an individual's complex needs. Because residential systems are as vulnerable to the effects of loss as the children and families they

[12] Greenspan, *Healing Through the Dark Emotions*.

[13] Boss, *Loss, Trauma and Resilience*, p.4

[14] McGoldrick and Boundy, *The Legacy of Unresolved Loss*

serve, the SELF model can be used to help organizations address their system-wide experiences of grief and loss (see Bloom, *this volume*).

Sadly, many agencies have experienced suicides and even homicides. When these tragedies occur, staff members are often so preoccupied and overwhelmed by trying to regain safety for their residents, talking to the press, and responding to investigations, that they may become numb and exhausted. As a result, frequently these institutional traumas are buried and not discussed. But, as organizations have used the SELF assessment, old painful memories are unearthed and the unresolved grief and shame are faced. Using SELF, the organizational community can find a way to be open about past losses and even memorialize a tragedy symbolically. For example, a tree or garden has been planted at some residential agencies after a suicide as a way of recognizing the loss of life and acknowledging the loss of that child's potential to be healed.

Another limiting aspect of coping with loss for residential care workers is that they are precluded by who they may talk to about work related tragedies. If the loss is related to one of organization's children or their families, the pledge of confidentiality prevents their discussing the situation in the way that other workers might typically process the loss. This is similar to the issue of "Coming Home"¹⁵ for Iraq and Vietnam War Veterans. A veteran of Iraq in recalling a devastating mortar attack on the chow hall of her unit (and the re-experiencing of the attack) later said: "It's stuff you can't talk about in the civilian world..."

The gap between home and work can be enormous. For example, in the work lives of staff in residential treatment, it is common to hear trauma histories of children that involve murder, rape and torture. These staff arrive home where family members more readily are able discuss their daily upsets or seek escape by tuning into *American Idol*. Being able to distance oneself from the job in a meaningful fashion is often too big a leap for many. The result? At times those who work in residential care may feel alienated from the normal support of their families.

Combat survivors refer to this sensation as feeling much like outsiders when they return home. Some maladaptive ways of coping as an outsider may be reflected in the use of substances and in broken family relationships. Numbing is an occupational habit reflected in organization stress, but this alienation can be addressed by the constant attention to the L of the SELF Model. The need to focus on organizational loss was evident for one residential treatment center when one of its former residents, Brenda committed suicide shortly after her discharge to another facility.

[15] Simon, *Bringing the War Home*, p.32.

Brenda

Brenda had struggled in with despair and many instances of self harming while in residential treatment. She had lost her family of origin, had failed foster care placements and was beginning to age out of the foster care system. The team had valiantly struggled to find a placement for this child and had finally succeeded. An adoption had gone through and the team had seen and heard reports of the benefits of her being adopted by a loving family. Her adoptive family was mindful and compassionate about the maturational needs of this former resident. Many of the older students at the agency knew her, and some of them had stayed in touch with her. Naturally, when the news of the suicide reached the agency, both staff and students were devastated.

Several staff proposed scheduling a series of L groups for the staff of the cottage where Brenda had lived. Other staff who had worked with this child were to be included. Some of the leaders in the organization thought it would be burdensome to an already profoundly sad group. They suggested L groups might decrease their ability to keep the structure of the residential unit and care for their current residents. Others persevered, recognizing that if they did not face the loss, then they would not be able to function in the present. Equally limiting, without facing loss, it would be impossible to move into the future.

The group that had worked with this child assembled. As they sat down, a staff member from another residential unit walked in, asking to join as a supportive participant for those who had worked with the deceased child. The positive impact of a sympathetic group who were there to offer support was palpable. As they talked about the loss, the more affected members of the staff recognized the benefits of having their colleagues express care and concern for *their* loss. This could easily have been a forgotten moment as the staff soldiered ahead in their day to day duties of caring for children who have been afflicted with many adversities and traumatic experiences. The staff group experienced first hand what it was to have care and support. Bereaved staff members did not have a sense of alienation; they had colleagues who were there to offer support, to help them discuss the loss. All colleagues—those who were mourning the loss of this young adult as well as those there to offer support—personally understood the value of loss work in a extremely unique and meaningful new context.

Conclusions

Not everything that is faced can be changed. But nothing can be changed until it is faced.

— James Baldwin

Coping with loss requires relationships and connection to others. In the past, grief work in many residential settings was limited to individual psychotherapy sessions. Many now see that this work often is most effective and best done in groups. One of the benefits of residential care is its congregative nature and therefore its ready availability of groups. With other participants and mourners, there is the opportunity to normalize the experience of loss. This dynamic reduces isolation and builds emotional connections with others who have experienced a similar loss. Holding loss groups in a residential unit or school offers the benefit of emphasizing community and cooperation by demonstrating that “classrooms can become places where (youth) learn to think about themselves as members of a whole that is greater than themselves”¹⁶.

Aside from loss or bereavement groups, psychoeducational groups are another very effective way of helping children and families understand the effects of exposure to trauma and adversity and ways that the SELF Model can serve as a framework for addressing these effects. Children in several residential settings that use the Sanctuary Model have described the surprising ease with which children understand the concepts of SELF and the effects of trauma. In the Sanctuary Model psychoeducation curriculum for children¹⁷ these concepts are conveyed through short lessons and participatory exercises, such as music and film clips. “In these sessions youths learn how healing from loss is connected to safety and emotions and how this is connected to a better future, how difficult it is to grieve, how people can get stuck when they are not able to grieve their losses, and how people need support when they are grieving so their safety can be maintained.”¹⁸.

For parents with children in residential care, education about the impact of intangible losses serves to empower and can facilitate the healing process for families. As part of treatment, parents can be encouraged to process the intangible losses they may have faced – losses of childhood, a sense of safety in the world, attachment relationships, the ability to manage emotions like other people, self esteem, capacity to establish healthy, nourishing relationships, good role models, conflict resolution skills, loss of ability to individuate, ability to let go of past, and a sense of wholeness. When families begin to acknowledge and understand the propensity to recreate these losses in their own lives and those of their families through reenactment, they can begin to interrupt that cycle of loss. Groups, individual and family work that focuses on loss can contribute to the development of the therapeutic community as more whole and humanized.

[16] Hardy and Laszloffy, p. 200

[17] See Sanctuary Leadership Development Institute, www.andruschildren.org

[18] Rivard et al, Preliminary Results of a Study, p.82

That need to humanize and create community also extends to the staff of residential treatment centers and the systems themselves. Allowing for opportunities to acknowledge institutional losses and community grief can serve to disrupt the perpetuation of traumatic loss for the organization and the clients they serve. Adopting the understanding that a residential treatment system is in many ways an organism that is vulnerable to the effects of trauma can help leaders and staff members treat each other and their organization with the same compassion that they show their clients.

Residential treatment centers are, by nature, grounded in loss. From the children served to the staff who serve, to the environment in which the organization exists, loss is an inextricable part of residential care. Despite this reality, loss is easily lost when there is so much emotional intensity in the lives of the children, the families and within the system. One residential treatment staff member recently shared a story about the pain and vulnerability of facing our losses, understanding that working through loss is a painful but necessary process for healing. He shared a moment of truth with his own daughter. She had cut her leg in a household accident. When her parents took her to the hospital for stitches, both mother and father were dreading seeing their child in pain. Despite the anesthesia, his daughter cried, "Daddy it hurts". At first he was speechless, then he heard himself say, "Honey, sometimes it's got to hurt so it can get better." With this understanding, residential settings will continue in the work of creating Sanctuaries where children and those who care for them can face their hurts in order to get better and move into a future with fewer burdens from the past.

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