Preliminary Results of A Study Examining the Implementation and Effects of a Trauma Recovery Framework for Youths in Residential Treatment

Jeanne C. Rivard, Ph.D.
National Association of State Mental Health Program Directors Research Institute
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
(703) 739-9333, Ext. 146
jeanne.rivard@nri-inc.org

Sandra L. Bloom, M.D.
Community Works
13 Druim Moir
Philadelphia, PA 19118
215-248-5357
S13132020@msn.com

David McCorkle, M.S.W.
Andrus Children's Center
1156 N. Broadway
Yonkers, NY 10701
914-965-3700
dmccorkle@jdam.org.

Robert Abramovitz, M.D.
Jewish Board of Family and Children's Services
120 W. 57th St
NY, NY 10019
(212) 632-4665
rabramovitz@jbfcs.org

The first author was on the faculty of Columbia University in New York City at the time the study described in this paper was conducted. The project was funded by the National Institute of Mental Health as an exploratory/developmental study (MH62896).

Abstract

Preliminary results are presented from a study that examined the implementation and short-term effects of the Sanctuary Model® as it is was being incorporated into residential treatment programs for youth. It was proposed that within the context of safe, supportive, stable, and socially responsible therapeutic communities, a trauma recovery treatment framework could be used teach youths effective adaptation and coping skills to replace non-adaptive cognitive, social, and behavioral strategies acquired as means of coping with traumatic life experiences. By the final wave of data collection, residential units implementing the Sanctuary Model were significantly stronger on dimensions of the treatment environment that measured support, autonomy, spontaneity, personal problem orientation, and safety, in comparison to residential units not implementing the model. Youth made gains over time in one measured domain of coping skills and on another scale assessing the extent to which they had a sense of control over their lives.

Introduction

This paper describes preliminary findings of a study, which examined the implementation and short-term effects of the Sanctuary Model® (Bloom, 1997) as it was being integrated into residential treatment programs for youth. The Sanctuary Model initiative is one of several projects being undertaken by a large nonprofit mental health and social service agency to better meet the trauma treatment needs of the children and families that it serves. The approach used in the Sanctuary Model fit with program needs to incorporate a trauma-focused intervention to address the special needs of youth with serious emotional disturbances and histories of maltreatment and/or exposure to domestic and community violence. Studies examining the characteristics of youths with serious emotional disturbances have shown that substantial proportions have histories of physical abuse, sexual abuse, neglect, or were removed from their homes due to abuse or neglect (Duchnowski, Hall, Kutash, & Friedman, 1998; Illback, Nelson, & Sanders, 1998; Quinn & Epstein, 1998; Silver, et al., 1992). However, treatment programs often do not address symptoms that may be related to prior traumatic experiences. The knowledge base on effective interventions for children who have experienced trauma is small, but a review of controlled trials of interventions for treating PTSD or PTSD-related symptoms in children and adolescents revealed that "the best available evidence" supports interventions containing cognitive-behavioral components such as exposure strategies, stress management and relaxation, cognitive/narrative structuring, and a parental treatment component (Cohen, Berliner, & March, 2000). Friedrich's (1996) treatment recommendations include strategies for modeling healthy attachments; and using cognitive behavioral techniques and psychoeducation to teach skills in accurately processing information, problem-solving, reducing agitation and managing anxiety, identifying and discriminating feelings, increasing self efficacy, and using feedback from others. The Sanctuary Model integrates an enhanced therapeutic community philosophy (Bloom, 1997), trauma theories (Bloom, 1997), and Friedrich's (1996) recommended child treatment strategies that address post-traumatic symptoms, developmental disruptions, and unhealthy accommodations to traumatic experiences.

The evaluation project was conducted as a partnership between researchers of Columbia University School of Social Work, the Center for Trauma Program Innovation of the Jewish Board of Family and Children's Services in New York City, and the model developer, Dr. Sandra Bloom. The research component of the project was funded through an exploratory/developmental research grant (MH62896) by the National Institute of Mental Health as part of an initiative to promote research on interventions for youth violence. Two previous reports have described the intervention, study design, and measures in greater detail (Rivard et al., 2003; Rivard et al., 2004).

Program Components of the Sanctuary Model

A fundamental premise of the Sanctuary Model is that the treatment environment is a core modality for modeling healthy relationships among interdependent community members. The Sanctuary Model challenges organizations to reexamine their basic assumptions concerning the extent to which treatment environments promote safety and nonviolence across physical, psychological, social, and moral domains. As such, the intervention is aimed both at strengthening the therapeutic community environment and at empowering youths to influence their own lives and communities in positive ways. The enhanced therapeutic community environment then sets the stage for the application of a trauma recovery framework (Foderaro & Ryan, 2000) and cognitive-behavioral strategies to teach youths effective adaptation and coping

skills to replace non-adaptive cognitive, social, and behavioral patterns acquired as means of coping with traumatic and other stressful life experiences. The trauma recovery framework accents the stages and critical tasks needed to affect recovery from traumatic life experiences (Foderaro & Ryan, 2000). To give meaning to the trauma recovery framework it is referred to as "SELF", which represents the four stages of recovery (Safety, Emotional management, Loss, and Future). *Safety* is translated as learning to attain safety in self, relationships, and the environment. Tasks in the *Emotional Management* stage focus on identifying and managing emotions in response to memories, persons, and events. Moving through *Loss* involves feeling grief and dealing with personal losses. The fourth aspect of recovery, *Future*, calls for trying out new roles and ways of relating and behaving as a survivor to ensure personal safety and help others.

The Sanctuary Model is operationalized through a series of staff dialogues and self evaluations of residential units' structure and functioning, staff training and on-going technical assistance, twice-daily community meetings, a range of pyschoeducation exercises that staff use in their daily interactions with youth, and weekly psychoeducation groups (Duffy, McCorkle, & Ryan, 2002) to teach knowledge and skills needed to progress through four stages of recovery.

The psychoeducation groups are organized around the SELF recovery framework and elements of the therapeutic community philosophy. The content of the curriculum used to conduct the groups is summarized as follows.

Sessions 1 and 2: Trauma Theory - The first two sessions are designed to help youths understand what we know and understand about the effects of trauma and violence; how people react to overwhelming stress with fight, flight, or freeze responses; how these stressful experiences affect peoples' thinking, feelings, and behaviors; and how these experiences can overwhelm people's ability to cope.

Session 3: Tools that Help People Build a Better Future - This session presents an overview of the SELF recovery framework, and introduces concepts and tools that will be covered in following sessions. The primary theme of this session is that youths will learn healthy ways of coping and problem solving that will help them build better futures for themselves.

Session 4 and 5: Safety - The next two sessions are designed to help youths increase their understanding of safety and to teach tools needed to establish and maintain safety on physical, psychological, social, and moral levels. The terms are explained to youths in the following ways. *Physical safety* includes safety within the environment where basic needs for nutrition, shelter, and sleep are met; where individuals are free from harm; and where comfort is provided. *Psychological safety* includes feeling safe in one's own mind. It means not hurting your own or others feelings. It includes the way you talk to your self and the way you talk to your peers, staff, and your family. *Social safety* means feeling safe and trusting other people. It is about choosing friends that you can trust. It also means being able to manage rough times and situations safely by talking rather than fighting. *Moral safety* means feeling safe enough to do the right thing, making good choices and doing your best to hold to them, respecting others, and having values that you and the people you are with live up to. If a peer is planning to hurt someone else, moral safety is telling the truth to protect your peers and staff.

Session 6: Safety and Boundaries – This session helps youths learn and practice safety principles with regard to boundaries. Youths are taught how to differentiate between physical and emotional boundaries, how to set their own boundaries, how to say yes or no when others want to come into their boundaries, and how to recognize when they violate the boundaries of others.

Sessions 7 and 8: Emotions – These two sessions focus on what feelings are and how feelings are an essential tool to have on the journey toward growing up healthy. Exercises show youths how to give names to feelings, how to think about what causes feelings, how to recognize various feeling signals in mind and body, how to understand ourselves better through our feelings, and how to manage the intensity of feelings without numbing or losing control.

Sessions 9 and 10: Loss – 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.

Sessions 11 and 12: Future – These sessions provide an opportunity for youths to begin to think about their futures. The emphasis is on teaching youth to navigate through each day with a better understanding of how their futures are determined by their abilities to keep themselves safe, to manage their emotions, to overcomes losses they have experienced, and to make choices that will help them reach their desired futures. Exercises show youths that they have a choice in creating their futures, and plant the seeds of hope for something different than what many youths have experienced in the past.

Methods

Design

Although the Sanctuary Model was in a very early stage of implementation, the evaluation was guided by hypotheses that projected what specific changes were expected to occur in the therapeutic communities and in youths. We expected to find greater changes over time in the Sanctuary Model units than in the standard residential services units in the following areas:

Therapeutic Communities

- Increase in perceived sense of community/cohesiveness
- Increase in democratic decision-making and shared responsibility in problem-solving
- Reduction in critical incidents and use of physical restraints

Youth

- Reduction in traumatic stress symptoms
- Increase in level of self esteem
- Greater internal locus of control
- Greater utilization of social network
- Improvement in decision-making and problem solving skills
- Decrease in aggressive behavior

A comparison group design, with measurement at three points (baseline, 3 months, 6 months), was used. The Sanctuary Model was first piloted in four residential units that self-selected to participate in the initial phase of the project. During this phase, the staff training protocol and manual was developed and piloted between February and August 2001. Four additional residential treatment units were randomly assigned to implement the Sanctuary Model in the Fall of 2001. Eight other units, providing the standard residential treatment program, served as the usual services comparison group.

The youth sample consisted of all youths for whom full informed written consent was obtained from custodial agencies, legal guardians, parents, and youths. The staff sample was composed of staff that worked in the programs and who voluntarily elected to participate in

surveys and focus groups through a process of fully informed, written consent. The human subjects protocol developed for this research project was reviewed and approved by the Columbia University Institutional Review Board and by applicable state and city agencies.

Measures

Implementation

A major emphasis of the evaluation was placed on assessing the processes of Model implementation. Progress in implementing the model was documented through consultants' process notes and periodic reviews of the Sanctuary Project Implementation Milestones checklist, which contained a list of observable criteria, by which implementation of the Model could be assessed. Qualitative data on staff perceptions of the course of implementation, and challenges in implementing the Model, were gathered through focus groups.

Youth Demographics and History

Demographic and historical data were abstracted from client records at baseline. History of abuse and neglect was abstracted from client records using the Maltreatment Classification System developed by Barnett, Manly, and Cicchetti (1993). Exposure to violence in home, community, or neighborhood was assessed through the My Exposure to Violence instrument (Buka, Selner-O'Hagan, Kindlon, & Earls, 1997).

Therapeutic Environment Outcomes

The short form of the Community Oriented Programs Environment Scale (Moos, 1996) was used to assess the extent to which units were operating as therapeutic communities along selected dimensions. The instrument measures three dimensions of program environments, with 10 subscales. The Relationship Dimension measures how active and energetic members are in the program (Involvement scale), how much members help and support each other (Support scale), and how much the program encourages the open expression of feelings by members and staff (Spontaneity scale). The Personal Growth Dimension measures self sufficiency and independence in decision-making and the extent to which members are encouraged to take leadership in the program (Autonomy scale), the extent to which members learn skills preparing them for discharge (Practical Orientation scale), the extent to which members seek to understand their feelings and personal problems (Personal Problems Orientation scale), and the extent to which anger and aggression are openly expressed in the environment (Anger and Aggression scale). The System Maintenance Dimension measures the extent to which programs are clearly structured and organized (Order and Organization scale) and the extent to which members know what to expect and the explicitness of program rules and procedures (Program Clarity scale). The COPES instrument was adapted slightly by deleting one scale originally intended to measure staff control and substituting this with a new scale intended to measure Sanctuary-specific dimensions related to the physical, social, and psychological safety of the environment for staff and clients (Safety scale). The short form of the COPES was used, which has 40 items, to reduce burden on staff that are asked to complete the questionnaire several times during the course of the study. The COPES was administered to staff four times at 4-6 month intervals. Considering potential differences in staff and youth perceptions, it would have been advantageous to also administer the COPES to youth. However, this method was not included in this initial study.

Youth Outcomes

The following instruments were used to assess youth outcomes that were hypothesized to be responsive to the Sanctuary model: Child Behavior Checklist (Achenbach, 1991), the Trauma Symptom Checklist for Children (Briere, 1996), the Rosenberg Self Esteem Scale (Rosenberg, 1979), the Nowicki-Strickland Locus of Control Scale (Nowicki & Strickland, 1973), the peer form of the Inventory of Parent and Peer Attachment (Armsden & Greenberg, 1987), the Youth Coping Index (McCubbin, Thompson, & Elver, 1996) and the Social Problem Solving Questionnaire (Sewell, Paikoff, & McKay,1996).

Results

Youth Demographics and History

Youths (*N*=158) ranged in age from 12 to 20 years, with a mean age of 15 years. Sixty-three percent were male and 37% were female. Thirty-three percent of youths were Hispanic; 47% were black, not Hispanic; 13% were white; 1% were Asian, Oriental, or Pacific Islander; and 6% were bi-racial or other. Youths averaged six prior placements, including an average of three psychiatric hospitalizations. A conservative analysis separating "alleged" from "substantiated" incidents of maltreatment showed that thirty-three percent of the youths had experienced at least one substantiated incident of physical abuse, 14% had at least one substantiated incident of sexual abuse, and 48% had at least one substantiated incident of neglect. Most youths experienced multiple incidents of maltreatment. A self-report of lifetime exposure to violence showed that 42% of youths had seen someone else attacked with a weapon, and that 23% had been attacked with a weapon themselves. Twenty percent reported having seen someone else shot, and 11% having been shot at.

Implementation

Across the eight units that implemented the model, scores on the Sanctuary Project Implementation Milestones criteria ranged from 66% to 92%, with a mean of 78%. The slowest and most difficult component to be implemented was the weekly psychoeducation group. Greater implementation was observed in units that were exposed longer to the model that served girls, and where leaders had greater enthusiasm and commitment to the Model.

Focus group questions were aimed at soliciting staff impressions concerning the implementation of the Model on their respective units. The first question asked participants to share what they thought were the most important principles and concepts of the Sanctuary Model. Focus group leaders stressed that the question was not intended as a test of what they learned in the prior training, but rather an attempt to find out what principles and concepts were most important to them in implementing the model. Principles and concepts mentioned as important included the SELF recovery framework, the central focus on safety, and the new sense of community and teamwork. Clinicians also stated that the use of trauma theories was helpful in illuminating the way that problems and behaviors of youths are linked to developmental interruptions, and in reorienting treatment toward a recovery path. Milieu counselors referred to learning new ways to problem-solve with staff and youths as being uniquely important to them. Both groups also stressed that the key to successful implementation was consistency in using the model. Table 1 summarizes the major categories and themes that emerged in staff responses to questions inquiring about the most important principles and concepts of the model and how these are incorporated into their work with each other and with clients.

Table 1. Focus Group Themes: Most Important Principles/Concepts

SELF Recovery Framework:
Provides a treatment guide that clarifies program goals.
Provides concrete tools for empowering youths.
Concept of loss increases understanding of the feelings and behaviors arising from losses that youths have experienced.
Focus on the future instills hopefulness and frees youth to think about alternative futures.
Safety and the New Sense of Community and Teamwork - Staff Interactions:
Increased awareness and dual concern for physical and psychological safety.
Prompts questions concerning how to create a safer culture.
Communication is integrally related to safety; reduces chaos and builds trust.
Greater psychological safety encourages open sharing of opinions, frustrations, and mistakes.
Greater communication and involvement has improved quality of team meetings.
More works needs to be done in flattening the traditional organizational hierarchy.
Many challenges still exist in bridging communication and trust gaps between clinical and direct care staff, and between administration and direct care staff.
Safety and the New Sense of Community and Teamwork - Direct Practice with Youths:
Safety plans encourage youths to take greater responsibility for their own treatment.
Safety plans promote consistency, but need to be used more uniformly within and across units.
Youths are taking on a greater leadership role in community meetings.
Community meetings prompt youths to reach out and help each other more.
Renewed sense of the community accepting the individual, but not his/her behavior.
Using Knowledge of Trauma Theories:
Knowledge of youths' trauma histories stimulates discussion of the implications for treatment.
Concepts and theories are used in therapy sessions.
More training is needed to translate this knowledge into daily practice on the residential units.
Therapists are learning how to discuss implications of their child's traumatic experiences with families without blaming or increasing guilt and remorse.
Using New Ways to Problem-Solve with Youths:
More emphasis is placed on exploring alternative actions and making good decisions.
Keeping youths focused on their individual goals has become more important.
Increased awareness of the need for consistency across the contexts of school and home.
More opportunities to rephrase individual problem behaviors in terms of their effect on the community.

Therapeutic Community Outcomes

No significant differences were found across the two conditions at baseline and during the next two waves of measurement. However, by the final wave of measurement, significant differences between the groups were found, via independent t-tests, with the Sanctuary Model units improving on the following constructs of the COPES: *support* ($p < .05$), *spontaneity* ($p < .01$), *autonomy* ($p < .05$), *personal problem orientation* ($p < .05$), *safety* ($p < .05$), and in the *total score* ($p = .001$). Table 2 presents results at the final wave of measurement for each of the 10 constructs of the COPES across both conditions. A COPES profile illustrating these findings in is shown in Figure 1.

Figure 1. COPES Profile for Sanctuary and Standard Residential Units

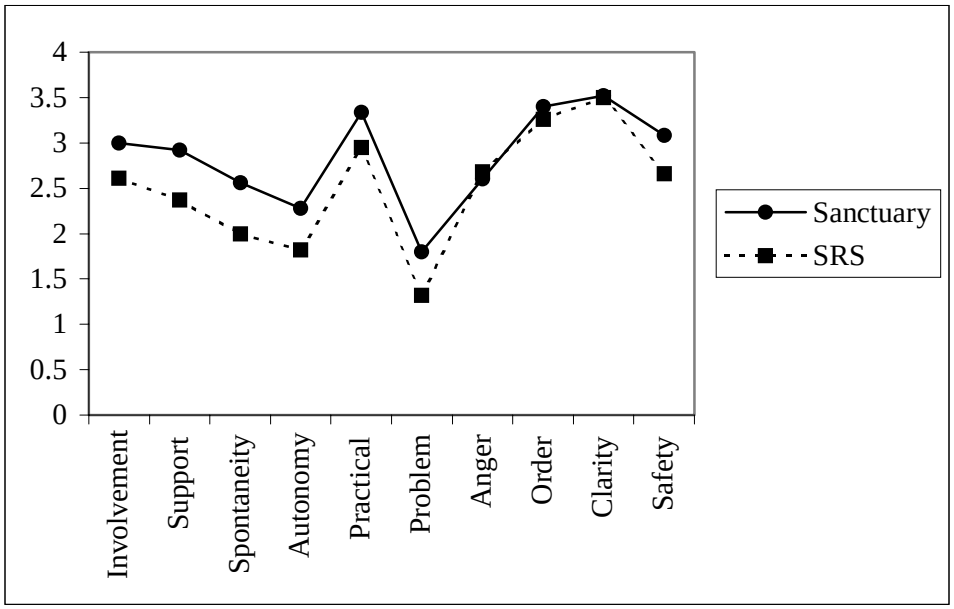

Table 2. Results of COPES at Final Wave of Data Collection

COPES Domain	Sanctuary Model		Standard Residential Services		
	Mean	S.D.	Mean	S.D.	P
Involvement	3.00	1.18	2.61	1.17	
Support	2.92	.97	2.37	1.13	.015
Spontaneity	2.56	.81	2.00	1.01	.005
Autonomy	2.28	.90	1.82	1.09	.032
Practical Orientation	3.34	1.08	2.95	.98	
Problem Orientation	1.80	1.09	1.32	.99	.034
Anger	2.60	.97	2.68	.99	
Order	3.40	.95	3.26	.95	
Clarity	3.52	.65	3.50	.76	
Safety	3.08	.72	2.66	1.02	.026
COPES Total	28.50	4.42	25.16	4.32	.001

Youth Outcomes

No significant differences were found comparing baseline and 3-month measures of youth outcomes. However, on repeated measures analyses (N = 87) comparing baseline and 6-month outcomes, a few differences were found, by time and group, which favored youth in the Sanctuary Model units. First, the incendiary communication/tension management scale of the Youth Coping Index scale measures "the degree to which youth adopt coping strategies that exacerbate interpersonal tensions and conflicts, and adopt appraisal strategies which minimize the significance of the problem or make the issue larger than it is" (McCubbin et al., 1996, p. 586). Between baseline and six months, youth in the Sanctuary Model significantly decreased over time in the desired direction, whereas scores of youth in the Standard Residential Services increased ($p < .05$). Second, scores on the Nowicki-Strickland Locus of Control Scale showed youth in the Sanctuary Model to decrease over time, or to become more internalizing, indicating a greater sense of control over their lives (versus externalizing, where fate or chance determines what happens to them). Scores of youth in the Standard Residential Services stayed roughly the same (p=.15). Third, on the verbal aggression scale of the Social Problem Solving Questionnaire, scores of youth in the Sanctuary Model decreased slightly over time, whereas youth in the Standard Residential Services increased in verbal aggression (p=.15).

Discussion

The Sanctuary Model was implemented in these residential treatment programs to specifically address the needs of children and youth that have experienced and often re-experienced the trauma of maltreatment and community violence. The term "complex trauma" is now being used to describe, both, the aspect of multiple exposure to traumatic events, and the enduring symptoms that can be manifested as children attempt to cope and integrate these traumatic experiences into their concepts of self, others, and their world (Cook, Blaustein, Spinazzola, & van der Kolk, 2003). The Sanctuary Model proposed that within the context of safe, supportive, stable, and socially responsible therapeutic communities, a trauma recovery treatment framework could be used to teach youths effective adaptation and coping skills to replace non-adaptive cognitive, social, and behavioral strategies acquired as means of coping with traumatic life experiences.

For the evaluation team the questions became: Could we successfully operationalize a multi-modal intervention that calls for changing the organizational culture while incorporating a new approach to treatment? Would staff and youth understand the model, accept it, and see the value in it? Could we measure incremental changes in the therapeutic communities? Would successful implementation actually lead to change in staff and youth behaviors?

Results of the first formal study to assess implementation of the model in this residential treatment setting show convergence in several findings, which support key aspects of the hypotheses. First, results of the early focus groups revealed that staff and youth were becoming more aware of their interdependence as community members. Youth began to develop more empathy for one another and for staff. A growing awareness of and understanding of trauma theories gave staff more understanding of the often-confusing youth behaviors that staff dealt with on a daily basis. The four-stage trauma recovery framework provided a stronger sense of direction in programming and additional tools for guiding youth. Thus, it appeared that the principle concepts of the model could be understood by staff and youth, and used to add greater value to the program.

Second, by the final wave of data collection, Sanctuary Model units were clearly distinguished from Standard Residential Services units on five constructs of the Community Oriented Program Environment Scale. The Sanctuary Model units scored significantly higher on scales measuring the extent to which:

- Community members help and support each other
- The program encourages the open expression of feelings
- The program promotes self-sufficiency and independence in decision making
- Community members seek to understand their feelings and personal problems
- The program environment promotes physical, social, and psychological safety for staff and clients

Third, consultants' monitoring of the Sanctuary Project Implementation Milestones Checklist showed variation in the extent to which the model was implemented across units. Comparing scores across the eight Sanctuary Model units showed that greater implementation was associated with higher scores on the COPES total score.

Finally, fewer changes were observed in youth outcomes than were hoped for. However, the few changes that were observed in youth outcomes over time and between the two groups suggest that youth in the Sanctuary Model units were decreasing antagonistic coping mechanisms and developing a greater sense of internal control. These findings are consistent with the results of the COPES that show a greater tendency of the Sanctuary Model units to encourage pro-social and self-reflective problem-solving.

Utilizing a comparison group design allowed us to assess differences over time and by group. More analyses of the data by individual residential unit and by youth characteristics will follow. Overall, the evidence found at this point is consistent with the ambitious new implementation of a large intervention aimed at strengthening both the treatment environment and the treatment approach. Results suggest that the Sanctuary Model, if implemented with greater fidelity and with more time can produce additional benefits for youth.

Further implementation and evaluation efforts should include: supporting implementation efforts with more intensive on-site technical assistance; promoting ongoing monitoring of change in the treatment environments and youths over time; and incorporating the use of brief behavior checklists that can be used as part of the regular program operations and may be more sensitive to change than relying primarily on three-month youth self-report measures.

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