Three Therapeutic Residential Care Models, the Sanctuary Model, Positive Peer Culture and Dyadic Developmental Psychotherapy and Their Application to the Theory of Congruence

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Therapeutic residential care for children and young people is a service model being implemented in the Queensland out-of-home care sector. Many therapeutic models for residential care exist; however, three that have research supporting their use include the Sanctuary model, positive peer culture model and the dyadic developmental psychotherapy residential model. This article will first outline the three models, with particular focus on the principles, strategies, current implementation and research related to each. It will then introduce Anglin's theory of congruence (2002) and outline how consistently each model corresponds to this theory.

∎ **Keywords:** out-of-home care, alternate care

Therapeutic residential care is a service model being funded within the Queensland out-of-home care sector within the last 24 months. The Department of Communities (Child Safety Services) has identified therapeutic residential care as the service model that will effectively meet the needs of young people in out-of-home care with complex and extreme behaviours and needs, who are a risk to themselves and others (Department of Child Safety, 2008). Given this new direction within the out-of-home care sector this article will explore three therapeutic approaches to out-of-home residential care, including the Sanctuary model, positive peer culture and dyadic developmental psychotherapy. It will look at the principles, strategies, current implementation and research related to each of the three models. It will then consider each of the models in relation to Anglin's theory of congruence, which research supports as a critical element of success for residential care services (Anglin, 2002).

Positive Peer Culture

Positive peer culture (known as PPC) is a therapeutic residential model based predominantly on the work of Harry Vorrath and Larry Brendtro (Vorrath & Brendtro, 2008).

The model is based on the notion that a young person is influenced by their own peer group, the culture and environment that surrounds them (Brendtro & Shahbazian, 2004). Vorrath and Brendtro (2008, p. 8) state that

> too often the peer group has been viewed only as a liability; too seldom has it been seen as a resource. Just as peer group influence can foster problems, so also can the peer process be used to solve problems.

The foundational concept of PPC is that troubled adolescents have positive potential and could become the source of their own and others' rehabilitation. It attempts to empower young people to utilise their assets and strengths to create positive values and behavioural change in themselves and others (Quigley, 2003). This model is used across various care settings in the United States, including child protection, correctional and school-based facilities, and varies in size from nine young people to over 100. The model requires each group or team to have nine or multi-

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ples of nine people (Vorrath & Brendtro, 2008). Of notable interest is the staff-to-young-person ratio, whereby nine young people to one staff member or group leader is considered sufficient (Vorrath & Brendtro, 2008).

PPC was initially developed in the 1950s for delinquent youth residing in group settings outside of their family. While this original setting saw the client group having delinquent and often criminal behaviours, they were also a group who had experienced abuse and neglect within their family environment, with the majority displaying complex and challenging behaviours (Brendtro & Ness, 1983). More recently, PPC has been used in a wide range of settings including schools, community programs, juvenile courts, group homes and other childcare facility, all with positive results (Vorrath & Brendtro, 2008). Research evidence has shown that PPC is seen as a treatment model relevant for young people exposed to emotional abuse, domestic violence, physical abuse, neglect and sexual abuse (Vorrath & Brendtro, 2008). Findings from various studies found a lessening of problematic behaviours, self-centredness, blaming of others, stealing and lying, significant improvement in social skills and reduced recidivism rates over a period of 12 months (Leeman, Gibbs, & Fuller, 1993; Nas, Brugman, & Koops, 2005; Sherer, 1985).

To operationalise PPC within a residential care setting the following elements are a focus:

- The peer group can best motivate and influence a young person to change behaviours and attitudes.
- Therapeutic intervention occurs within peer groups of nine young people.
- The young people spend close to 100% of time together within a peer group.
- Experiential learning occurs within the group setting resulting in the therapeutic needs of the young person being met.
- To truly empower young people within a PPC group, the leadership and authoritative role of adults must be diminished.
- Adults guide the helping process. (Center for the Study and Prevention of Violence, 2005; Moody, & Lupton-Smith, 1999; Quigley, 2003; Trieschman, Whittaker, & Brendtro, 1997; Vorrath & Brendtro, 2008)

Vorrath and Brendtro (2008, p. xxii) state that 'PPC asks much of youth in the knowledge that people seldom will be more responsible than they are expected to be or more helpful than they are allowed to be'.

PPC aims to assist young people in a variety of ways, including learning to develop an internal control and sensitivity to others around them, to manage their behaviour no matter the situation and to be able to develop long-term thinking that includes self-identification of values, goals and beliefs. It is expected that, as a result of the treatment experience, young people will assume responsibility for helping one another and responsibility for their own

behaviours by refraining from blaming others or using excuses (Moody et al., 1999). In summary, PPC aims to assist young people to learn basic values associated with being respectful and thoughtful of others. This results in increased self-awareness, positive self-image and increased concern for oneself and others, together with an improved ability to make rational competent decisions (Moody et al., 1999; Quigley, 2004). 'The central position of Positive Peer Culture is that young people can develop self-worth, significance, dignity, and responsibility only as they become committed to the positive values of helping and caring for others' (Vorrath & Brendtro, 2008, p. 4).

The tools utilised within the therapeutic environment centre around four areas:

- *Building group responsibility:* members learn to keep each other out of trouble, by exerting powerful influence over one another's behaviour.
- *Group meetings:* a problem-solving process in which young people assist each other to solve problems within a structured meeting format that can occur up to five times a day.
- *Service learning:* young people engage in multiple community projects to reinforce the value of helping others while reinforcing the notion of community responsibility and providing the context for young people to experience positive relationships with adults.
- *Teamwork primacy:* the staff teams are organised around distinct groups of young people, with management's highest administrative priority being the teamwork within the staff teams, as this facilitates the therapeutic intervention within the model (Gable & Arllen, 1994; Quigley, 2004; Vorrath & Brendtro, 2008).

Overall, PPC creates the belief that problems can be viewed as opportunities. It focuses on the present with the expectation that young people are instrumental in the success of therapeutic intervention and can increase the likelihood of positive change in attitude and interpersonal behaviours (Moody et al., 1999).

The Sanctuary Model

The Sanctuary model is a trauma-informed systems approach to residential care programs for young people suffering from the effects of maltreatment and exposure to family and/or community violence (Bloom, 2003). While the Sanctuary model is applied to various settings, this article is focused on its application to children and young people in care and the implementation of a program that responds to extremely complex clients with deeply embedded injuries including biological, affective, cognitive, social and existential wounds (Bloom, 2003; Rivard, McCorkle, Duncan, Pasquale, & Bloom, 2004). Within a group context, the model aims to provide the individual with the necessary skills for creating and sustaining nonviolent lives. It does so by redefining basic assumptions about the

nature of the problem/s, the optimal environment and skills needed for effective treatment, the impact of loss on youth and the need for shared vision about treatment outcomes (Abramovitz & Bloom, 2003; Rivard et al., 2004).

The Sanctuary model focuses on the concept of trauma, recognising the impact of such events as being so profound that it tends to freeze people in time, trapping them in a seemingly endless loop of destructive repetition that is conveyed from one generation to the next via disruptions in attachment relationships (Bloom, 2005). Traumatic experiences result in the child/young person repeating the same destructive intrapsychic and interpersonal behaviours without recognising the patterns of repetition and without the skills for managing the extremely distressing emotions associated with change. The use of this model within a residential setting aims to address this issue (Bloom, 2005).

The Sanctuary model is utilised in over 100 programs across the world. These residential services have placement numbers ranging from eight young people to over 100, with clients who have been exposed to violence, neglect and other forms of traumatic experiences (Bloom, 2005). Sanctuary residential care facilities accommodate children and young people who characteristically are unable to keep themselves safe in the world and can put others at risk of harm. Bloom (2005, p. 10) describes the young people as

> chronically tense and hyperaroused with hair-trigger tempers and a compromised ability to manage distressing emotions. This emotional arousal interferes with the development of good decision-making, problem solving skills and conflict resolution skills, and as a result, the ability to communicate constructively with others does not develop properly. This results in grave cognitive, emotional and interpersonal difficulties.

Research related to the use of this model has shown that young people accommodated within the residential care facility exhibited increased coping skills, greater sense of personal control and reduced use of verbal aggression (Rivard, Bloom, McCorkle, & Abramowitz, 2005). In 2006, a 5-year longitudinal study involving 18 of the Sanctuary services, was undertaken to validate the model's outcomes for children, young people and families. Findings to date have shown the use of this care model results in significant decreases in restraints, critical incidents, staff turnover as well as increased positive staff perception of the organisational climate (Banks & Vargas, 2008).

The Sanctuary model integrates four key theoretical positions, including trauma theory, social learning theory, nonviolent practice and complexity theory (Abramovitz & Bloom, 2003). Trauma theory or a trauma recovery treatment framework is used to teach clients effective adaptation and coping skills to replace nonadaptive cognitive, social and behavioural strategies that have emerged as a result of coping with the previous trauma (Bloom,

2004). The model uses social learning theory, which emphasises the active use of a safe, supportive, stable and socially responsible environment as a therapeutic agent of change. Nonviolent practice is also critical to the therapeutic change that can occur for children and young people. This practice emphasises safety as an active, attitudinal and political aspect of social life and the organisation as a whole. The final theoretical element of the Sanctuary model is complexity theory, which provides a way to conceptualise how complex adaptive systems, like individuals and organisations, can utilise their innate capacity to change (Abramovitz & Bloom, 2003). Critical to the Sanctuary model is the foundational concept that to treat children and young people, the organisation must also reexamine its own basic assumptions concerning the extent to which it promotes safety and nonviolence. The organisation must itself be a therapeutic community that empowers and influences the lives of individuals and communities in a positive way (Bloom, 2004).

The Sanctuary model requires service commitment to nonviolence, emotional intelligence, inquiry and social learning, democracy, open communication, social responsibility, growth and change. The model uses a number of tools to guide children and young people through their recovery and healing. The SELF framework is the trauma-informed tool utilised with children and young people. Bloom (2005, p. 13) describes the elements of SELF as:

> Safety: attaining safety in self, relationships and environment
>
> Emotional Management: identifying levels of affect and modulating in response to memories, persons and events
>
> Loss: feeling grief and dealing with personal loss
>
> Future: trying out new roles, ways of relating and behaving as a 'survivor' to ensure personal safety and help others.

This framework provides a simple, understandable and comprehensive way for the clients, their families and staff to make sense of, and respond constructively to, very complex dilemmas. Essential elements of the program are:

- building a child/young person staff partnership
- flattening the organisational hierarchy by emphasising the importance of democracy, thereby reaffirming the importance of all voices including children/young people, families and staff
- using SELF, the unifying, phase-specific trauma treatment framework, which empowers everyone to consider treatment within the context of Safety, Emotion, Loss and Future
- promoting community building based on SELF principles of shared responsibility between staff and children/young people in maintaining a safe, nonviolent environment (Abramovitz & Bloom, 2003).

Other key therapeutic strategies or tools used to assist healing include community meetings. These daily forums

are used to distribute information in an open and public arena in which a process for decision-making allows participants to receive personal feedback. It also provides a forum where participants can exert pressure on those who are not conforming to the agreed-upon norms (Bloom, 2004). Another tool used within the Sanctuary model is safety plans. These plans are not only used for children and young people but also for the staff in the residential care facility. The plans are simple and provide options for immediate steps that can be used to de-escalate stressful, challenging and dangerous situations (Bloom, 2004). Services utilising the Sanctuary model require a service curriculum that provides key learning and training opportunities for staff and client participation is seen as critical. This tool assists children and young people develop the skills and competency to self-govern via participation in service delivery. The final critical therapeutic tool for the Sanctuary model is evaluation. This regular process of review, evaluation and reflection allows problems and issues to be resolved (Bloom, 2004).

Many children and young people requiring residential care have been exposed to some form of trauma during their childhood. The Sanctuary model outlines a framework for working with these young people and for creating an environment that encourages growth; and assists in addressing certain emotions and behaviours ultimately resulting in better life outcomes (Bloom, 2005).

Dyadic Developmental Psychotherapy

Dyadic developmental psychotherapy (DDP) is a treatment approach used to provide an attachment-based residential program and is based on the work of Daniel Hughes (Doyle-Buckwalter & Robison, 2008). The key principles of DDP include the development of attunement. Attunement is the central process for developing parent–child attachment. When matched positive affective states occur within the parent-child relationship (i.e., feelings of joy, excitement and fun) this results in the relationship being contented and satisfying (Hughes, 2007). Attunement is central to the healing of children and young people with significant attachment issues (Hughes, 1997). DDP aims to assist children and young people to develop primary and secondary intersubjectivity. Daniel Hughes (2007, p. 29) identifies primary intersubjectivity as the 'interactional process in which children's view of self emerges from their experience of what their parents are recognising and responding to'. Secondary intersubjectivity is the process whereby a child or young person can share attention, feelings and intentions regarding an object, event or action with another person (Hughes, 1997). DDP strives to assist in the development of an integrated autobiographical narrative. Finally, the model attempts to assist the child or young person to see their past trauma within the context of a different narrative, therefore exposing how the current narrative has distorted their relationships and influenced behaviours. This allows the child or young person, together with the adults in their lives, to modify these working models in a way that supports the formulation of functional relationships (Doyle-Buckwalter & Robison, 2008). Because DDP is usually used within a therapy session with the child and parent, the primary difference with its application to the residential setting is that the worker takes on the parent role within the therapeutic intervention (Blackwell & McGuill, 2008).

Chaddock's integrative attachment therapy residential program has utilised DDP within the service. Chaddock's model suggests the ideal treatment or residential period as being between 9 and 18 months, with children and young people aged between 8 and 16 years living within cottage-style residential care facilities (Doyle-Buckwalter & Robison, 2008). Three pieces of research have been undertaken relating to the DDP approach to residential care. The first study examined the demographic and clinical characteristics of children and young people in the program over a 2-year period. This study highlighted the extreme complexity of the children and young people cared for within the residential setting. It found that, on average, the residents stayed for 17 months; 72% were male with severe externalising problems (aggression etc.), most also suffered internalising problems (depression etc.) and over half exhibited risk behaviours (sexual acting out, suicidal or homicidal gestures) (Blackwell & McGuill, 2008). The second and third study focused on outcomes of the program, including behavioural, self-report and psychological changes for the children and young people within the first study. The studies found statistically significant positive changes in externalising problems, conduct problems and depression. Additionally, statistically significant changes were found in reality testing, healthier perceptions of human interactions, more mature conflict resolution skills, improved self-reliance, less cognitive confusion under stress, less distorted reasoning and decreased feelings of rejection and depression (Blackwell & McGuill, 2008). These studies, while small, show the positive impact of this model within a residential setting.

Staff are seen as critical to the success of DDP. Attachment-based residential settings involve the entire staff group's relationship with the child or young person as the primary agent of change. It is understood that the quality of the day-to-day relationship with staff, who must function like a parent to the child or young person, is the crucible for healing (Hughes, 1997). The model involves staff focus on the here and now with children and young people, while the therapy sessions focus on the past. It is believed that past trauma, if not addressed, can distort current relationships therefore undermining the progress being made. Nurturance is provided to children and young people no matter what behaviour they are exhibiting. This is consistent with the basic notion relating to

attachment; that children must have opportunities to experience nurturance, not because they earn it but because they need and deserve it (Doyle-Buckwalter & Robison, 2008). Staff training is another critical element to the success of DDP. Staff need to have a comprehensive and internalised understanding of attachment theory, trauma theory and the stages of healing. They also need to have developed the ability to reframe a child or young person's resistant behaviour as indicating success for the child. DDP requires staff to have the PACE attitude — that is, an attitude of Playfulness, Acceptance, Curiosity and Empathy (Doyle-Buckwalter & Robison, 2008). PACE is central in the early attachment process experienced between infants and parents and therefore, when applied to the care of children and young people who have poor attachment due to experiencing significant abuse and/or neglect from parental figures, PACE results in the formation of attachment (Hughes, 2006). PACE itself is a therapeutic tool for treatment (Hughes, 2007). This final staff element of DDP requires staff teams and supervisors to provide a supportive environment where there is also an emphasis on self-care and the need for staff to continually reflect on their own issues (Doyle-Buckwalter & Robison, 2008).

DDP provides a safe, nurturing environment whereby the approach to all children and young people is guided by the message that 'we will care for you' (Blackwell & McGuill, 2008). The residential care facility is also guided by the following concepts:

- Children get what they need, not what they earn.
- Nurturance is a right of the child.
- Fairness is getting what you need not that same amount or the same thing as another child.
- True change is based on intense interpersonal relationship, and is not technique driven.
- Everyone has permission to feel.
- All moments in the interactions with the child are seen as therapeutic opportunities.
- Care prioritises alliances rather than compliance. (Blackwell & McGuill, 2008, p. 149).

Within the residential care facility, staff members have only three rules for children and young people. Rule 1: The child needs to ask for everything s/he needs and wants. This promotes the concept that staff will meet the child's needs as well as promoting a dependency interaction between staff and the child. Rule 2: Staff must know where the child is at all times. This rule allows the child to understand that staff cannot care about them and keep them safe if they do not know where they are. Rule 3: No hands on without permission. This rule allows the child to understand that they will not be hurt. It also aims to teach children or young people that meaningful relationships should not hurt (Blackwell & McGuill, 2008).

In addition to the key principles mentioned previously, DDP also utilises other strategies within the residential setting, including rhythm control. This strategy refers to the positive emotional and behavioural state of the staff within the residential setting. This is a regulatory process that helps to manage the PACE attitude of staff and processing of the child or young person's emotions and behaviours within the residential care facility (Blackwell & McGuill, 2008). Supportive control is another strategy utilised. This is the process whereby discipline is the demonstration of nurturance, therefore strengthening the adult–child relationship. Supportive control is undertaken in a proactive manner so that it assists the child to meet the adult's expectation, rather than respond negatively to the situation (Blackwell & McGuill, 2008). The final strategy is closeness. Children and young people experience a feeling of safety when staff members maintain a level of closeness. This strategy aims to portray the message that staff or adult caregivers will be present for the child or young person even during difficult times. This strategy also promotes an interrelatedness and reciprocity within a healthy relationship (Blackwell & McGuill, 2008).

DDP within a residential care setting has three developmental stages:

Trust of Care ⇨ Trust of Control ⇨ Trust of Self

Within the trust of care stage, the dependency on staff is emphasised. This can take the form of keeping doors locked, maintaining proximity, overt supervision, safety touches, smiling and unsolicited nurturance. The aim of this stage is to create a secure base that allows the child or young person to trust that staff are doing what is best for them (Blackwell & McGuill, 2008). Trust of control involves staff demonstrating nurturing discipline and control. This provides limit-setting to assist the child or young person to meet adult expectations and involves staff assisting children and young people to regulate their behaviours and emotions through the process of co-regulating. The complex experiences during this stage are intended to contribute to the permanency of the relationship (Blackwell & McGuill, 2008). The final stage is trust of self. This treatment phase involves the child or young person receiving more trust and responsibility for themselves. They have the ability to self-regulate and seek help and support when experiencing times of deregulation, together with positive feelings about others and even caring about them. It is towards the very end of this stage that the transition from the residential setting to home occurs (Blackwell & McGuill, 2008). These developmental stages allow staff to assist children and young people to experience real and long-lasting positive differences in the world around them.

DDP within a residential setting provides an opportunity for children and young people who have severe and profound effects due to attachment- and trauma-related

experiences, to develop functional, reciprocal and positive relationships that result in better life outcomes.

The Theory of Congruence and Therapeutic Residential Care

In 2002, Dr James Anglin published *Pain, Normality And The Struggle For Congruence,* which detailed a 2-year research study of residential care services in North America. A central question for this study was 'What makes a well functioning residential?' Dr Anglin, using an initial sample from over 500 residential services, found that while the residential services had different approaches, strategies, theoretical foundations, staff and organisational profiles and client groups, those services that had successful outcomes for children and young people all had one thing in common. They had a high level of congruence across 11 interactional dynamics at all levels of the organisation: contractual level, managerial, supervisory, carework/team, youth and family (Anglin, 2002).

The interactional dynamics include:

- listening and responding with respect
- communicating a framework for understanding
- building rapport and relationship
- establishing structure, routine and expectations
- inspiring commitment
- offering emotional and developmental support
- challenging thinking and action
- sharing power and decision-making
- respecting personal space and time
- discovering and uncovering potential
- providing resources. (Anglin, 2002, p. 57)

When considering that congruence has been found to be a critical element of a successful residential service, the question for this article is: do the Sanctuary, PPC and DDP models address the need for congruence across the 11 interactional dynamics at all levels of the organisation?

The PPC model strives to have congruence across all levels of the organisation on key dynamics; however, it appears to omit the contractual level. The PPC literature provides explicit direction for the organisation, management, careworkers and youth in relation to the program's structure, how to communicate and understand young people, relationship-building and the sharing of power (Anglin, 2002; Vorrath & Brendtro, 2008). Vorrath and Brendtro (2008) provide very detailed direction for organisations and management on how to form appropriate staffing groups and how to reconceptualise the organisation so that it supports the utilisation of PPC. This direction provides a basic knowledge for developing congruence across the interactional dynamics. But PPC does not state how the contractual or funding agency fits with the model. Nevertheless, the application of the key principles, strategies and PPC's whole-of-system

approach would allow users to develop congruence at a contractual level with ease. The risk is that, without the knowledge of Dr Anglin's work, an agency could implement the model without achieving congruence because it does not ensure that congruence is achieved at the funding or contractual level.

The Sanctuary model and its literature provide the greatest level of direction in striving for congruence. Sanctuary's systemic approach to care provision means that all levels of the organisation are required to become trauma-informed, committed to nonviolence, emotional intelligence, inquiry and social learning, shared governance, open communication, social responsibility and growth and change (Bloom, 2005). The model outlines in detail how this must occur at all levels, including a contractual level. The model's principles, theoretical basis and strategies require all levels of an organisation to adequately understand the key interaction dynamics including routine, structure, communicating understanding, establishing relationships and rapport, offering emotional and developmental support and so forth. The Sanctuary model and its literature support the findings of Dr Anglin and his congruence theory, in that the model explicitly states again and again that, unless the whole-of-system's approach is implemented and functional across all levels of the organisation, true healing for children and young people will not occur (Bloom, 2005).

DDP addresses the key concept of congruence throughout its literature. All levels of the organisation, except the contractual level, are mentioned when detailing the model, its principles and key strategies. The critical role of the organisation and management within DDP is detailed in relation to the provision of staff training, staff support and supervision, and how the residential care facility itself should be managed to support the healing of the child or young person (Doyle-Buckwalter & Robison, 2008). DDP also provides high levels of guidance for caseworkers, the child/young person and family in relation to how the model works in terms of the interactional dynamics (for example, guiding how staff are to respond to the young person, how they can communicate their understanding, structure of the program, how to listen and respond respectfully, the provision of emotional and developmental support, shared decision-making etc.). The stages of treatment, key principles including attunement, intersubjectivity, PACE and other strategies allow congruence to occur for all levels of the organisation (Blackwell & McGuill, 2008). While the literature does not explicitly mention how DDP interacts with the contractual or external funding agencies, the detailed nature of the model would enable service users to develop their own contractual level of congruence. DDP has a similar deficit in relation to congruence as PPC. While DDP provides the key knowledge required to form congruence, the need to do so across all levels of the organisation is not emphasised and therefore, without the knowledge of Dr Anglin's

work, agencies could implement the model without achieving congruence.

The Sanctuary model, positive peer culture and the dyadic developmental psychotherapy model show tremendous capacity to assist children and young people to experience care provision that results in better life outcomes. The research outcomes associated with each model support the fact that each model has its place in meeting the varied needs of children and young people requiring out-of-home care. All three models show a pronounced correlation to congruence theory, which is seen as an element consistently found in successful residential care settings. The most exciting element associated with these models is the fact that each appears to improve the life outcomes of children and young people who have experienced high levels of trauma associated with abuse and neglect.

References

Abramovitz, R., & Bloom, S.L. (2003). Creating sanctuary in a residential treatment for youth: From the 'Well-ordered asylum' to a 'Living-learning environment'. *Psychiatric Quarterly, 74*(2), 119–135.

Anglin, J.P (2002). *Pain, normality, and the struggle for congruence: Reinterpreting residential care for children and youth.* New York: Haworth Press.

Banks, J., & Vargas, L.A. (2008). *Preliminary outcomes: Sanctuary in childcare settings* (Andrus Center for Learning and Innovation research brief). New York: Andrus Children's Center.

Blackwell, S., & McGuill, J. (2008). Dyadic developmental psychotherapy in a residential treatment. In A. Becker-Weidman & D. Shell (Eds.), *Creating capacity for attachment: Dyadic developmental psychotherapy in the treatment of trauma-attachment disorders* (pp. 143–163). New York: Wood 'N' Barnes.

Bloom, S.L. (2003). The Sanctuary model: A trauma-informed systems approach to the residential treatment of children. *Residential Group Care Quarterly 4*(2), 4–5.

Bloom, S.L. (2004). *Creating sanctuary: Organizing safe environments for healing.* Retrieved 15th June 2005, from: www.ohsu.edu/psychiatry

Bloom, S.L. (2005). The Sanctuary model of organizational change for children's residential treatment. *Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations, 26*(1), 65–81.

Brendtro, L., & Shahbazian, M. (2004). *Troubled children and youth: Turning problems into opportunities.* Champaign: IL: Research Press.

Brendtro, L., & Ness, A.E. (1983). *Re-educating troubled youth: Environments for teaching and treatment.* New York: Aldine De Gruyter.

Center for the Study and Prevention of Violence. (2005). *Blueprints model programs Multidimensional Treatment Foster Care (MTFC).* Retrieved April 7, 2008, from: http://www.colorado.edu/cspv/blueprints/model/programs/details/MTFCdetails.html

Department of Child Safety. (2008). *Service model for therapeutic residential services.* Retrieved on July 15, 2010, from: http://www.childsafety.qld.gov.au/funding/documents/trcs-model-final.pdf

Doyle-Buckwalter, K., & Robison, M. (2008). Using dyadic developmental psychotherapy in a residential treatment centre. In A. Becker-Weidman & D. Shell (Eds.), *Creating capacity for attachment: Dyadic developmental psychotherapy in the treatment of trauma-attachment disorders* (pp. 132–143). New York: Wood 'N' Barnes.

Gable, R.A., & Arllen, N.L. (1994). Use of students with emotional/behavioral disorders as behavior change agents. *Education & Treatment of Children, 17*(3), 267–277.

Hughes, D.A (1997). *Facilitating developmental attachment: The road to emotional recovery and behavioural change in foster and adopted children.* New York: Jason Aronson.

Hughes, D.A. (2006). *Building the bonds of attachment: Awakening love in deeply troubled children* (2nd ed.) New York: Jason Aronson.

Hughes, D. (2007). *Attachment focused family therapy.* New York: W.W. Norton.

Leeman, L.W., Gibbs, J.C., & Fuller, D. (1993). Evaluation of a multi-component group treatment program for juvenile delinquents. *Aggressive Behavior, 19*, 281–292.

Moody, E.E., Jr., & Lupton-Smith, H.S. (1999). Interventions with juvenile offenders: Strategies to prevent acting out behavior. *Journal of Addictions & Offender Counseling, 20*(1), 2–15.

Nas, C.N., Brugman, D., & Koops, W. (2005). Effects of the EQUIP programme on the moral judgement, cognitive distortions, and social skills of juvenile delinquents. *Psychology, Crime, & Law, 11*(4), 421–434.

Quigley, R. (2003). The Colorful evolution of a strength-based treatment model. *Reclaiming Children and Youth, 12*(1), 28–33.

Quigley, R. (2004). Positive peer groups: 'Helping others' meets primary developmental needs. *Reclaiming Children & Youth, 13*(3), 134–137.

Rivard, J.C., Bloom, S.L., McCorkle, D., & Abramowitz, R. (2005). Preliminary results of a study examining the implementation and effects of a trauma recovery framework for youths in residential treatment. *Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations, 26*(1), 83–96.

Rivard, J., McCorkle, D., Duncan, M., Pasquale, L., & Bloom, S. (2004). Implementing a trauma recovery framework for youth in residential treatment. *Child and Adolescent Social Work Journal, 21*, 529–550.

Sherer, M. (1985). Effects of group intervention on moral development of distressed youth in Israel. *Journal of Youth and Adolescence, 14*(6), 513–526.

Trieschman, A.E., Whittaker, J.K., & Brendtro, L. (1997). *The other 23 hours: Child care work with disturbed children in a therapeutic milieu.* New York: Aldine De Gruyter.

Vorrath, H.H., & Brendtro, L.K. (2008). *Positive peer culture* (2nd ed.) London: Aldine Transaction.